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
	AL11967943	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA COLONIA 1 ALF, INC	830 NE 10TH LANE CAPE CORAL, FL 33909

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced survey for complaint 2023011742 was conducted [redacted] at La Colonia I, an Assisted Living Facility in Cape Coral, Florida. Complaint 2023011742 was substantiated at A0007, A0010, A0053, and A0077 at Class I level. With A0009, A0054, A0162, and A0166 at Class III level. The following is a description of the deficiencies.	A 000		
A 007 SS=J	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least [redacted]. 2. Be free from signs and symptoms of any communicable [redacted] that is likely to be transmitted to other residents or staff. An individual who has [redacted] ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional	A 007		

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A 007	Continued From page 1 qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a health care practitioner, or a mental health practitioner licensed under Chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 10. Not have any [illegible] or 4 [illegible]. A resident requiring care of a [illegible], may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care practitioner; b. The condition is documented in the resident's record and admission and discharge logs; and, c. If the resident's condition fails to improve within	A 007		

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A 007	Continued From page 2 30 days as documented by a health care practitioner, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with , c. Monitoring of gases, d. Management of post-surgical drainage tubes and vacuum devices; e. The administration of products in the facility; or f. Treatment of surgical or , unless the surgical or and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. , and , , performed in the facility; b. , , performed in the facility. 13. Not require 24-hour nursing supervision, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 14. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and	A 007		

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A 007	Continued From page 3	A 007		

preferences of the individual;
b. The medical examination report required by Section 429.26, F.S.;
c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and,
d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule Chapter 69A-40, F.A.C.
(b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable ,, or assistance with routine , care of site , placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves.
(c) Nursing staff may not provide training to unlicensed persons, as defined in Section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from , with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license.
(d) Not withstanding any other provisions of this rule, an individual enrolled in and receiving licensed hospice services may be admitted to an assisted living facility pursuant to Section

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A 007	Continued From page 4 429.26(1)(d), F.S. (e) Resident admission 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 record review, family and staff interview, and observation the facility's administrator failed to properly determine the appropriateness of admission to the facility for 1 (Resident #1) of 2 residents reviewed requiring assistance with self-administration of . The facility's administrator admitted Resident #1, an dependent , who required injections of . The resident was not able to self administer her . The facility did not have a licensed nurse on staff or make arrangements for the resident to be administered by a qualified licensed nurse. Failure to provide required services to a resident (Resident #1) resulted in the resident's hospitalization on with a diagnosis of . The resident was rehospitalized on in an unresponsive state with a diagnosis of , Acute , failure, , , and . All residents requiring assistance with administration of are in imminent danger or have a substantial probability that or serious physical harm could result. This deficient practice is at a Class I level. The findings included: The reviewed Administrator's Job Description states: Policies: The Administrator is in charge of the entire operation of the ALF and is responsible for all	A 007		

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A 007	Continued From page 5 personnel supervision and assure that all resident's needs are met. This includes the conduct of the employees and the assurance of the wellbeing of all the residents in the ALF ... Procedure: The Administrator must: 4- Understand the rules and regulations that govern ALF operation. 5- Comply with these requirements. 6- Provide staff with clear directions to follow [in] order to fulfill the goals of the ALF. 7- Be responsible for determining the appropriateness of admission of resident to the facility. 8- Be responsible for determining the continued appropriateness of residence in the facility. The Administrator is in charge of his/her own responsibilities including but not limited to the following: 2- Orienting and training the new employee, 3- Maintaining effective supervision of all employees in the completion of their duties. Record review for Resident #1 of the Resident Health Assessment, AHCA Form 1823, completed by the physician on ... documents the resident is an , female with , , and Type II requiring injections. The physician responded to the statements on the 1823 form: "Can the individual's needs be met in an assisted living facility, which is not a medical, nursing, or , facility?' The physician marked, Yes. "Does the individual need help with taking his or her medications?", with the explanation, "this allows unlicensed staff to assist with , , , oral, , and , medications". The physician marked, Yes. Injections are not included. The resident was admitted to this facility on	A 007		

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A 007	Continued From page 6 . . . . . from a sister facility. Review of the resident records in this facility revealed on admission, there was no resident agreement, no physician order for , and no order for . . . . . monitoring. A Medication Observation Record (MOR) was initiated on for giving . . . . . , 30 units every morning. The MOR is initiated by the Medication Technician/Caregiver (MedTech) as . . given on . . . . . through at 8:00 a.m. The MOR indicates that . . was not given on . . . . . There were no instructions to check the level prior to administering the . . . . However, a . . . . . Testing Log was initiated on with a routine check at 8:00 a.m. The Log is documented by the MedTech. On , and there were additional . . . . . checks documented. The . Testing Log documents: Date Value Time . . . . . 271 at 8:00 am 246 . . 247 277 . . . . 211 150 at 8:00 am , 170 at 12:00 pm, 34 at 4:00 pm . . 110 at 8:00 am, 120 at 4:00 pm . . . . . 70 at 7:00 am, 80 at 10: am, Hi (No number) at 12:00 pm, Low/ then 40 at 12:37 PM Resident #1 has a dedicated , an electronic . . . . . monitoring device, for her use only. A review of the memory showed the following history: Date Time Value . . . . 9:25a 193 4:16p 77 . . . 10:40a 228 2:15p 64	A 007		

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A 007	Continued From page 7	A 007		

2:36p 186
6:46a 73
7:31a 70
9:20a 79
11:01a High
11:27a Low
11:35a 46
11:43a Low

Observation of the packaging for the used for Resident #1 found there was no label with the name of the resident, the dose to be given, or the frequency of administration on the box containing the vial of nor on the vial.

Progress Notes in Resident #1's record document the resident was sent to the hospital twice in the first eight days in the facility:
- "We sent her to the hospital because her [going] down ( ). She came same day. She doing better but she continued with her sugar up and down." Problems with Medication is marked, No.
- "We sent her to the hospital because her to hight [was too low] then when she (staff) took the the was too hight [high] and we called 911 to take her to the hospital." Problems with Medication is marked, No.

In an interview on at 8:52 a.m., MedTech Staff A said she used a syringe to draw up 30 units of she then gave the syringe to Resident #1 to inject it herself. She confirmed that she is not a licensed nurse. MedTech Staff A said that on at 4:27 p.m., she noticed Resident #1 looked pale lying in her bed. She said she performed an Accu-check of level with a reading of 34 (a dangerously

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A 007	Continued From page 8 low level). Staff A said she called 911, notified the family, and the facility manager. A review of Staff A's personnel record revealed she was hired on ..... as a caregiver and medication technician. She completed her 6-hour initial medication training on ..... The most recent 2-hour medication training was completed on ..... She also completed an additional 2 hours of medication training on . There is no record that Staff A received training for checking . In an interview on at 10:33 a.m., the Manager and Staff A said that on ..... the Paramedics arrived soon after being called, provided ..... to Resident #1, and transported the resident to the hospital. They said Resident #1 returned to the facility later that evening on . The hospital record states Resident #1's ..... reading at 6:15 p.m. on ..... was ... up to 176. The hospital ER record for lists the admitting complaint as, "..... female presented to the emergency department with ..... She apparently became ..... and poorly responsive. She was found by ... to be ..... ." The hospital discharge instructions regarding stated, "..... should be monitored carefully by the staff at the facility. should be carefully administered only after confirming that patient is eating and adequate ... levels." On at 10:57 a.m., Staff A said on Friday, ... at 8:00 a.m. the ..... reading was normal, and she administer 30 units of to Resident #1. Staff A and the Manager said that Resident #1 was stable on Friday .. Staff	A 007		

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A 007	Continued From page 9 A said that on Resident #1's reading was 70 at 7:00 a.m. Staff A said she gave Resident #1 milk, orange juice, and bread with margarine for breakfast. Staff A said Resident #1 was fine. She said at 10:00 a.m. another check was performed with a reading of 80. The resident had orange juice. Staff A said at 12:00 noon she went to the resident's room and determined she was fine, no health issues. Staff A said she performed another check with a reading of 'high'; there was no number on the screen. Staff A said she administered 30 units of to the resident, the only dose that day. This dose of is not documented on the MOR. Staff A said on at 12:37 p.m. she went to check on Resident #1 and escort her to lunch. She said at that same time the resident's family arrived at the facility. Staff A and the family members found the resident on the floor in her room. Staff A said the resident was not responding to verbal requests. She said the resident was not responsive, but breathing. Staff A completed another check and the monitor displayed a reading of 'low'; there was no number on the screen. Staff A called 911 and paramedics arrived at 12:54 p.m. Staff A said she did not understand what values for level were indicated by Low or High displayed on the . The Run Record for states the primary impression was Acute , Distress. The secondary impression was . The level checked by the EMT upon arrival at 12:55 p.m. was 41. The resident was transported to the hospital. The ER Encounter Record states Resident #1's care was taken over by ER staff at 1:55 p.m. The admitting diagnosis was , Acute	A 007		

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A 007	Continued From page 10 failure, , and . The medical history recorded by the ER physician states: Patient "is a resident of a residential ALF who presents to the emergency department via Ambulance with complaints of unresponsive state. Apparently, the patient received her normal a.m. dose of despite having a of 70 and allegedly did not eat. She was found an hour or two later unresponsive with low was summoned. They found her and ended up giving a 25 g of . The did improve but the mental status did not." The patient was admitted to the unresponsive and placed on a . In a telephone interview on at 1:02 p.m., Resident #1's primary physician said the resident has been under his care for a month or so. He said the resident was admitted initially to another assisted living facility and she came with medications from home that were brought in by Resident #1's daughter. The physician said a representative of the first facility explained to the daughter they had no nurses on staff so they would need an order for a pre-loaded , in ordered for the resident to stay in the facility. The physician said there was a problem with Resident #1's health insurance, they did not cover the , . The physician said since there were multiple issues with Resident #1's insurance, he had to submit the request to Resident #1's insurance company multiple times. The physician provided copies of orders prescribing and . He said he did not have an order on record dated when the resident was admitted to the second facility, a sister facility to the first. The physician provided documentation of orders dated , , give 30 units SQ ( )	A 007		

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A 007	Continued From page 11 every morning. An order dated for , 100 unit/ml suspension give 30 units in AM and Accu-checks 3 times daily. And an order dated for , give 30 units. The orders dated and for were not filled. There was no on premises. On at 4:22 p.m., the facility Manager and Administrator were interviewed. The Manager said that, upon admission on , the family provided for the resident. The manager said the family member instructed the staff to administer 30 units by injection every morning. The manager confirmed there was no prescription from a physician for the . The manager said they acted in good faith and used the vial provided by the resident's daughter in order to accommodate the resident and the family since Resident #1's insurance refused to pay for a pre-loaded . The manager acknowledged it was an error in judgement and she should have obtained orders. She also acknowledged it was an error to accept that was not labeled with resident's name, practitioner's name, date dispensed, name and strength of the drug, directions for use, and expiration date. The administrator confirmed Staff A did not follow proper procedure when assisting Resident #1 with self-administration of medications. He said he was under the impression that under the new rule staff can dial an or the dosage on a syringe as long as they do not inject the but let the resident do it. He said he misinterpreted the regulation and acknowledged the error. The Manager confirmed that MedTech Staff A, the staff member who administered the , was not a licensed nurse and that there are no licensed nurses on staff at the facility.	A 007		

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A 007	Continued From page 12 In a telephone interview on at 9:53 a.m., Resident #1's son-in-law verified that the .. was brought to the facility by his wife. He said his wife would pick up the resident's medications from the pharmacy and take everything to facility. He acknowledged the facility was trying to change from syringes to the , and they were working on it. He said the facility management was aware that his mother-in-law was using syringes when she was admitted to the facility on , and they accepted her into the facility. On at 12:19 p.m., the son-in-law said that prior to admission to the facility, the resident's daughter was the one that assisted Resident #1 with her since the resident is not able to do that herself. He said the resident has and would not be able to manage .. herself. The family member said the facility management told him that, supposedly, Staff A was just preparing the injection and the resident was injecting the .. herself. He stated, "That is a big lie. She would not be able to do that. What kind of [made up story] is that. A big lie." On at 1:00 p.m., the son-in-law said the facility management never asked the family if the resident could self-administer by drawing up the syringe or by injecting the medication. The daughter said the resident has and for nine years she has had do everything for the resident related to administering . The daughter said the resident cannot do it for herself. In a telephone interview on at 1:28 p.m., the Administrator said he did not test the resident when she first came to the facility to see if she could inject the . He said he did not arrange to have the for Resident #1	A 007		

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A 007	Continued From page 13 administered by licensed nurse. Class I	A 007		
A 009 SS=D	59A-36.006(3) FAC; 400.0078(2) Admissions - Admission Package (3) ADMISSION PACKAGE. (a) The facility must make available to potential residents a written statement(s) that includes the following information listed below. Providing a copy of the facility resident contract or facility brochure containing all the required information meets this requirement. 1. The facility's admission and continued residency criteria; 2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provided by the facility for that rate; 3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any; 4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any; 5. Food service and the ability of the facility to accommodate special diets; 6. The availability of transportation and additional costs to the resident, if any; 7. Any other special services that are provided by the facility and additional cost if any; 8. Social and leisure activities generally offered by the facility; 9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any; 10. The facility rules and regulations that	A 009		

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	AL11967943	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA COLONIA 1 ALF, INC	830 NE 10TH LANE CAPE CORAL, FL 33909

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A 009	Continued From page 14 residents must follow as described in Rule 59A-36.007, F.A.C.; 11. The facility policy concerning . . . pursuant to Section 429.255, F.S., and Rule 59A-36.009, F.A.C., and Advance Directives pursuant to Chapter 765, F.S.; 12. If the facility is licensed to provide extended congregate care, the facility's residency criteria for residents receiving extended congregate care services. The facility must also provide a description of the additional personal, supportive, and nursing services provided by the facility including additional costs and any limitations on where extended congregate care residents may reside based on the policies and procedures described in Rule 59A-36.021, F.A.C.; 13. If the facility advertises that it provides special care for individuals with 's and related . . . . . , a written description of those special services as required in Section 429.177, F.S.; and, 14. The facility's resident elopement response policies and procedures. (b) Before or at the time of admission, the resident, or the resident's responsible party, guardian, or attorney-in-fact, if applicable, must be provided with the following: 1. A copy of the resident's contract that meets the requirements of Rule 59A-36.018, F.A.C., 2. A copy of the facility statement described in paragraph (a) of this subsection, if one has not already been provided, 3. A copy of the resident's bill of rights as required by Rule 59A-36.007, F.A.C.; and, 4. A Long-Term Care Ombudsman Program brochure that includes the telephone number and address of the district office. (c) Documents required by this subsection must be in English. If the resident is not able to read, or	A 009		

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A 009	Continued From page 15 does not understand English and translated documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident. 400.0078 (2) Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding: (a) The purpose of the State Long-Term Care Ombudsman Program. (b) The statewide toll-free telephone number and e-mail address for receiving complaints. (c) Information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. (d) Other relevant information regarding how to contact representatives of the State Long-Term Care Ombudsman Program. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a complete admission packet was available for new admissions to the facility. Failure to provide a complete admission packet leads to a lack of necessary information and may lead to misunderstanding between the resident or their representative and the facility. The findings included: A review of the facility's records revealed that upon admission on the facility did not provide an admission packet to Resident #1, or the resident's responsible party including a Facility Resident Agreement and the facility's admission and continued residency criteria. The	A 009		

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A 009	Continued From page 16 facility did not provide the facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications. On at 1:00 p.m., the son-in-law said they did not sign a new contract with the facility when Resident #1 moved in on . He said the family provides the resident's medication. He said facility management never asked the family if the resident could self-administer by drawing up the syringe or by injecting the medication. In a telephone interview on at 1:28 p.m., the Administrator confirmed that they did not have a contract for Resident #1 for this facility. He said the resident was in a sister facility and transferred to this facility due to behaviors with consent of the family. He said at some time, not yet determined, they expected the resident would return to the first facility. A review of the facility admission packet and contract showed that facility's agreement excluded the following information. 1. The facility's policies and procedures for self-administration, assistance with self-administration, and administration of medications, if applicable, pursuant to rule 59A-36.008, F.A.C. 2. No reference was made in relation to residents not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. 3. Documentation indicating whether or not facility	A 009		

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A 009	Continued From page 17 is affiliated with a religious organization. On . . . . at 4:15 p.m., the Manager acknowledged the lack of documentation. Class III	A 009		
A 010 SS=J	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 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,	A 010		

Agency for Health Care Administration

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A 010	Continued From page 18 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 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	A 010		

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A 010	Continued From page 19 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, 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	A 010		

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A 010	Continued From page 20 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 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	A 010		

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A 010	Continued From page 21 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 record review, family and staff interview the facility's administrator failed to properly determine the continued appropriateness of residency in the facility for 1 (Resident #1) out of 2 residents reviewed. The facility's administrator admitted Resident #1, an dependent , without having a licensed nurse on staff and did not make arrangements for the resident to be administered by a qualified licensed nurse. Within six days of admission to the facility, Resident #1 was transported by to the hospital due to a episode. Upon the resident's return to the facility, the administrator failed to reassess the appropriateness of residency and failed to arrange for management by a qualified licensed nurse. Within two days after returning from the hospital, Resident #1 experienced another episode that rendered her unresponsive. transported the resident to the hospital where she was admitted to the and placed on a . Continued residency in the facility placed the resident in imminent danger of a substantial probability that or serious physical or emotional harm would result at a Class I level. Findings included: The reviewed Administrator's Job Description states: Policies: The Administrator is in charge of the entire operation of the ALF and is responsible for all personnel supervision and assure that all resident's needs are met. This includes the	A 010		

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A 010	Continued From page 22 conduct of the employees and the assurance of the wellbeing of all the residents in the ALF ... Procedure: The Administrator must: 4- Understand the rules and regulations that govern ALF operation. 5- Comply with these requirements. 8- Be responsible for determining the continued appropriateness of residence in the facility. Record review for Resident #1 found the Resident Health Assessment, AHCA Form 1823, completed by the physician on . documents the resident is an ... female with , and Type II ..... requiring ... injections. The physician documented the resident's needs could be met in an assisted living facility, which is not a medical or nursing facility. The physician also documented the resident needs help with taking her medications. However, this does not included injections. Resident #1 was admitted to the facility on . A review of the Medication Observation Record (MOR) reveals Resident #1 was to be given , 30 units every morning. There are no instructions for checking ..... levels or parameters on limiting administration based on ..... levels. A Medication Technician/Caregiver (MedTech) documented on the MOR that Resident #1 received a dose of on , , , ..., ..., ..., and ..... Though there were no orders to check the level prior to administering the .... a ..... Testing Log was initiated on with a routine check at 8:00 a.m. On ....., ... and ..... there were additional checks. Progress Notes in Resident #1's record document	A 010		

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A 010	Continued From page 23 the resident was sent to the hospital twice in the first eight days in the facility: - "We sent her to the hospital because her [going] down ( ). She came same day. She doing better but she continued with her sugar up and down." Problems with Medication is marked, No. - "We sent her to the hospital because her to hight [was low] then when she (staff) took the the was too hight [high] and we called 911 to take her to the hospital." Problems with Medication is marked, No. In an interview on at 8:52 a.m., MedTech Staff A said she used a syringe to draw up 30 units of she then gave the syringe to Resident #1 to inject it herself. She confirmed that she is not a licensed nurse. MedTech Staff A said that on at 4:27 p.m., she noticed Resident #1 looked pale lying in her bed. She said she performed an Accu-check of level with a reading of 34 (a dangerously low level). Staff A said she called 911, notified the family, and the facility manager. A review of Staff A's personnel record revealed she was hired on as a caregiver and medication technician. She completed her 6-hour initial medication training on . The most recent 2-hour medication training was completed on . She also completed an additional 2 hours of medication training on . There is no record that Staff A received training for checking . In an interview on at 10:33 a.m., the Manager and Staff A said Resident #1 returned to the facility later that evening on .	A 010		

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A 010	Continued From page 24 The hospital ER Encounter Record for lists the admitting complaint as, " female presented to the emergency department with . She apparently became and poorly responsive. She was found by to be ," The hospital discharge instructions regarding stated, " should be monitored carefully by the staff at the facility. should be carefully administered only after confirming that patient is eating and adequate levels." A review of the resident's record revealed a new prescription dated for , give 30 units. There were no new orders for monitoring. Observation in the facility found no evidence of on the premises. Only one vial of was found. A review of the MOR revealed the MedTech continued to document administration of . No arrangements were made for a qualified third-party caregiver to monitor Resident #1's levels and administer . On at 10:54 a.m., the Manager said Resident #1's insurance company did not cover pre-loaded , and that is why they accepted the vial of from the family. The Manager confirmed that MedTech Staff A is not a licensed nurse and that there are no licensed nurses on staff at the facility. On at 10:57 a.m., Staff A said on Friday, at 8:00 a.m. the reading was normal, and she administered 30 units of to Resident #1. Staff A and the Manager said that Resident #1 was stable on Friday . Staff A said that on , Resident #1's	A 010		

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A 010	Continued From page 25 reading was 70 at 7:00 a.m. Staff A said at 10:00 a.m. another check was performed with a reading of 80. Staff A said at 12:00 noon she went to the resident's room and determined she was fine, no health issues. Staff A said she performed another check with a reading of 'high'; there was no number on the screen. Staff A said she administer 30 units of to the resident, the only dose that day. This dose of is not documented on the MOR. Staff A said on at 12:37 p.m. she went to check on Resident #1 and found the resident on the floor in her room. Staff A said the resident was not responsive but breathing. Staff A completed another check. She said the monitor displayed a reading of 'low', there was no number on the screen. Staff A said she did not understand what values for level were indicated by Low or High displayed on the . Staff A called 911 and paramedics arrived at 12:54 p.m. The Run Record for states the primary impression was Acute Distress. The secondary impression was . The level checked by the EMT upon arrival at 12:55 p.m. was 41. The resident was transported to the hospital. The ER Encounter Record states Resident #1's care was taken over by ER staff at 1:55 p.m. The admitting diagnosis was , Acute , failure, , and . The medical history recorded by the ER physician states: Patient "is a resident of a residential ALF who presents to the emergency department via Ambulance with complaints of unresponsive state. Apparently, the patient received her normal a.m. dose of despite having a of 70 and allegedly did	A 010		

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A 010	Continued From page 26 not eat. She was found an hour or two later unresponsive with low [illegible] was summoned. They found her [illegible] and ended up giving a 25 g of [illegible]. The [illegible] did improve but the mental status did not." The resident was admitted to the hospital [illegible] and placed on a [illegible]. On [illegible] at 4:22 p.m., the Facility Manager and the Administrator were interviewed. The Administrator confirmed Staff A did not follow proper procedure when assisting Resident #1 with self-administration of medications. The Manager confirmed that MedTech Staff A, the staff member who assisted with the [illegible], was not a licensed nurse and that there are no licensed nurses on staff at the facility. Class I	A 010		
A 053 SS=J	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary	A 053		

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LA COLONIA 1 ALF, INC	830 NE 10TH LANE CAPE CORAL, FL 33909

(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 053	Continued From page 27 for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including [illegible] testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review, family and staff interview the facility failed to evaluate a resident's ability to self-administer [illegible] and failed to arrange for a resident to be administered by a qualified licensed nurse for 1 (Resident #1) of 2 residents reviewed with self-administration of [illegible]. The facility failed to ensure unlicensed medication technicians (MedTech) did not provide services outside the scope of their training and abilities by allowing the MedTech to prepare and administer [illegible] for Resident #1. Lack of qualified nursing staff resulted in life threatening events for Resident #1 who was transported via [illegible] to the hospital twice within the first eight days of admission with a diagnosis of [illegible]. On the second visit [illegible], Resident #1 was	A 053		

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A 053	Continued From page 28 admitted to the hospital , , and placed on a . All residents requiring assistance by a licensed nurse for administration of are in imminent danger or have a substantial probability that or serious physical harm could result. This deficient practice is at a Class I level. Findings included: Florida Statute 7-429.256(4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses. (b) The preparation of syringes for injection or the administration of medications by any injectable route. Record review for Resident #1 found the Resident Health Assessment, AHCA Form 1823, completed by the physician on documents the resident is an female with , and Type II requiring injections. The 1823 form documents the resident needs assistance with self-administration of medication. A review of the Medication Observation Record (MOR) reveals Resident #1 was to be given , 30 units every morning. There were no physician orders found in the resident's record for and no orders for checking levels. There were no parameters for limiting administration based on levels. A MedTech documented on the MOR that Resident #1 received a dose of on , , , , , and . Though there were no orders to check the level prior to administering the , a Testing Log was initiated on with a MedTech signing off on a routine	A 053		

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A 053	Continued From page 29 monitoring each morning at 8:00 a.m. On , and there were additional checks. In an interview on at 8:52 a.m., MedTech Staff A said she used a syringe to draw up 30 units of she then gave the syringe to Resident #1 to inject it herself. She confirmed that she is not a licensed nurse. Staff A said she was not aware she cannot draw into a syringe. She said she thought it was ok to prepare the syringe but just not be the one to inject the resident. MedTech Staff A said that on at 4:27 p.m., she noticed Resident #1 looked pale lying in her bed. She said she performed an Accu-check of level with a reading of 34 (a dangerously low level). Staff A said she called 911, notified the family, and the facility manager. The hospital ER Encounter Record for lists the admitting complaint as, " female presented to the emergency department with . She apparently became and poorly responsive. She was found by to be ." The hospital discharge instructions regarding stated, " should be monitored carefully by the staff at the facility. should be carefully administered only after confirming that patient is eating and adequate levels." A review of Staff A's personnel record revealed she was hired on as a caregiver and medication technician. She completed her 6-hour initial medication training on . The most recent 2-hour medication training was completed on . She also completed an additional 2 hours of medication training on . There is	A 053		

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A 053	Continued From page 30 no record that Staff A received training for checking . In an interview on at 10:34 a.m., the Manager acknowledged that Staff A is not a licensed nurse. Manager said she was not aware that an unlicensed medication technician is not allowed to draw into the syringe. A review of the Progress Notes for Resident #1 revealed that Resident #1 was sent to the hospital again on having been found on the floor of her bedroom unresponsive. The Med Tech called 911. The Run Report for states the primary impression was Acute , Distress. The secondary impression was . The level checked by the EMT upon arrival at 12:55 p.m. was 41. The resident was transported to the hospital. The ER Encounter Record states the admitting diagnosis was , Acute failure, , , and . The medical history recorded by the ER physician states: Patient "is a resident of a residential ALF who presents to the emergency department via Ambulance with complaints of unresponsive state. Apparently, the patient received her normal a.m. dose of despite having a of 70 and allegedly did not eat. She was found an hour or two later unresponsive with low was summoned. They found her and ended up giving a 25 g of . The did improve but the mental status did not." The resident was admitted to the hospital , and placed on a . On at 4:22 p.m., the facility manager said that, upon admission on , the family provided for the resident. The	A 053		

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A 053	Continued From page 31 manager said the family member instructed the staff to administer 30 units by injection every morning. The administrator confirmed Staff A did not follow proper procedure when assisting Resident #1 with self-administration of medications. He said he misinterpreted the regulation and acknowledged the error. The Manager confirmed that MedTech Staff A, the staff member who assisted with the , was not a licensed nurse and that there are no licensed nurses on staff at the facility. In a telephone interview on at 12:19 p.m., Resident #1's son-in-law said his wife (Resident #1's daughter) for the past 9 years was the one that assisted the resident with her . He said the resident was not able to do that herself due to . He said the facility manager told him that, supposedly, Staff A was preparing the syringe and his mother-in-law was injecting the herself. The son-in-law stated, "That is a big lie. She would not be able to do that. What kind of [a made-up story] is that. Big lie." He said the resident is not capable of preparing the syringe or injecting herself. In a telephone interview on at 1:28 p.m., the Administrator and Manager said the family never told them the resident was not capable of injecting the herself. The administrator said he did not test the resident when she first came to the facility to see if she could inject the . Class I	A 053		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS.	A 054		

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A 054	Continued From page 32 (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review, observation, and staff interview facility failed to ensure an up-to-date Medication Observation Record (MOR) for 1 (Resident #1) of 2 residents reviewed for medications. Findings included:	A 054		

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A 054	Continued From page 33 A review of the health care record for Resident #1 reveals the resident was admitted to this facility on from a sister facility with a diagnosis of , and Type II requiring injections. Further review of the resident's records in this facility found, that on admission, there was no resident agreement, no physician order for , and no order for monitoring. A Resident Health Assessment, AHCA Form 1823, completed by the physician on and MOR for came with the resident from the previous facility. There was no list of prescribed medications with the Form 1823. The MOR from the prior facility listed the following medications: POT, , , and with the dose, route of administration, and frequency. The MOR does not include the known the resident may have or the name of the resident's health care provider and the health care provider's telephone number. The MOR from the previous facility was continued to be used in this facility from through . The MOR does not include on the list of medications. Upon admission a new sheet was added to the MOR listing one medication; give 30 units every morning. There was no order or instructions to check the level prior to administering the . However, a Testing Log was initiated on with a routine check at 8:00 a.m. The Log is documented by the Medication Technician (MedTech). The MOR is initialed by the MedTech as given on through at 8:00 a.m. The MOR indicates that was not	A 054		

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A 054	Continued From page 34 given on ..... On .... at 10:57 a.m., Staff A said that on ..., Resident #1's ... reading was 70 at 7:00 a.m. Staff A said at 12:00 noon she went to the resident's room and determined she was fine, no health issues. Staff A said, at that time, she performed another ... check with a reading of 'high'; there was no number on the screen. Staff A said she then administer 30 units of .. to the resident, the only dose that day. This dose of ... was not documented on Resident #1's MOR. Staff A could not provide an explanation as to why the administration of the ... was not documented on the MOR. Staff A said that on ... at 12:37 p.m., she found the resident on the floor in her room. Staff A said the resident was not responsive but breathing. Staff A completed another ... check, and the monitor displayed a reading of 'low'; there was no number on the screen. Staff A said she did not understand what values for ... level were indicated by Low or High displayed on the ... . Staff A called 911. The unresponsive resident was admitted to the hospital ... and placed on a .... In an interview on ..... at 4:00 p.m., the Manager acknowledged that Staff A did not follow proper procedure and did not accurately document the medication observation record for Resident #1. The Manager confirmed a new properly documented MOR was not set up for this new admission. Class III	A 054		

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A 077	Continued From page 35	A 077		
A 077 SS=J	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C.,	A 077		

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A 077	Continued From page 36 and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.	A 077		

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A 077	Continued From page 37 (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile . . . . of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , . . , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not . . . . . , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, ... ; which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on record review and interview the	A 077		

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A 077	Continued From page 38 administrator failed to supervise the operation of the facility to provided appropriate care for 1 (Resident #1) of 2 residents receiving . The administrator failed to ensure qualified caregivers were assigned to administer to Resident #1, a resident with Type II . Management failed to obtain orders from Resident #1's health care practitioner for and for testing level. The facility failed to assess the resident's ability to participate in self-administration of . Failure to provide proper services to a resident resulted in Resident #1's hospitalization on for . The unresponsive resident was admitted to the and placed on a . All residents requiring assistance with administration of are in imminent danger or have a substantial probability that or serious physical harm could result. This deficient practice is at a Class I level. The findings include: The reviewed Administrator's Job Description states: Policies: The Administrator is in charge of the entire operation of the ALF and is responsible for all personnel supervision and assure that all resident's needs are met. This includes the conduct of the employees and the assurance of the wellbeing of all the residents in the ALF ... Procedure: The Administrator must: 4- Understand the rules and regulations that govern ALF operation. 5- Comply with these requirements. 6- Provide staff with clear directions to follow [in] order to fulfill the goals of the ALF. 7- Be responsible for determining the appropriateness of admission of resident to the	A 077		

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A 077	Continued From page 39 facility. 8- Be responsible for determining the continued appropriateness of residence in the facility. The Administrator is in charge of his/her own responsibilities including but not limited to the following: 2- Orienting and training the new employee, 3- Maintaining effective supervision of all employees in the completion of their duties. Review of Resident #1's records found the resident was admitted to the facility on with diagnosis of and Type II . There was no documentation of physician orders for administration or testing. Resident #1's Medication Observation Record (MOR) review revealed that an unlicensed medication technician (MedTech) signed off on giving the resident , 30 units every morning for the dates to . The medication package containing the vial of was not labeled with the name of the resident, the dose to be given, or the frequency of administration. A Testing Log was initiated on with a routine check at 8:00 a.m. The checks were signed off as completed by the MedTech. Progress Notes in Resident #1's record document the resident was sent to the hospital twice in the first eight days in the facility: - "We sent her to the hospital because her [going] down ( ). She came same day. She doing better but she continued with her sugar up and down." Problems with Medication is marked, No. - "We sent her to the hospital because her to hight [meant too low] then when she (staff) took the the was too hight [high] and we called 911 to	A 077		

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A 077	Continued From page 40 take her to the hospital." Problems with Medication is marked, No. In an interview on at 8:52 a.m., MedTech Staff A said she used a syringe to draw up 30 units of she then gave the syringe to Resident #1 to inject it herself. She confirmed that she is not a licensed nurse. MedTech Staff A said that on at 4:27 p.m., she noticed Resident #1 looked pale lying in her bed. She said she performed an Accu-check of level with a reading of 34 (a dangerously low level). Staff A said she called 911, notified the family, and the facility manager. A review of Staff A's personnel record revealed she was hired on as a caregiver and medication technician. She completed her 6-hour initial medication training on The most recent 2-hour medication training was completed on She also completed an additional 2 hours of medication training on There is no record that Staff A received training for checking . The hospital ER Encounter Record for lists the admitting complaint as, " female presented to the emergency department with She apparently became and poorly responsive. She was found by to be ." The hospital discharge instructions regarding stated, " should be monitored carefully by the staff at the facility. should be carefully administered only after confirming that patient is eating and adequate levels." On at 10:57 a.m., Staff A said that on at 12:00 p.m. she performed another	A 077		

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	AL11967943	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA COLONIA 1 ALF, INC	830 NE 10TH LANE CAPE CORAL, FL 33909

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A 077	Continued From page 41 . . . . . check with a reading of 'high'; there was no number on the screen. Staff A said she administered 30 units of . . . to the resident. This dose of was not documented on the MOR. Staff A said she went . . . to check on Resident #1 at 12:37 p.m. to escort her to lunch. Staff A said the resident was not responsive but breathing. She completed another . . . . . 's check and the monitor displayed a reading of 'low'; there was no number on the screen. Staff A called 911 and paramedics arrived. The , . . resident was transported to the hospital, admitted to the and placed on a . On at 4:22 p.m., the Facility Manager and the Administrator were interviewed. The manager said that, upon admission on , the family provided . . . . . for the resident. The manager said the family member instructed the staff to administer 30 units by injection every morning. The manager confirmed there was no prescription from a physician for the . . . . The manager said they acted in good faith and used the vial provided by the resident's daughter in order to accommodate the resident and the family since Resident #1's insurance refused to pay for a pre-loaded , . . The manager acknowledged it was an error in judgement and she should have obtained orders. She also acknowledged it was an error to accept . . that was not labeled with resident's name, practitioner's name, date dispensed, name and strength of the drug, directions for use, and expiration date. The Administrator confirmed Staff A did not follow proper procedure when assisting Resident #1 with self-administration of medications. He said he was under the impression that under the new rule staff can dial an , . . or the dosage on a	A 077		

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A 077	Continued From page 42 syringe as long as they do not inject the .. but let the resident do it. He said he misinterpreted the regulation and acknowledged the error. The Manager confirmed that MedTech Staff A, the staff member who assisted with the , was not a licensed nurse and that there are no licensed nurses on staff at the facility. In a telephone interview on .. .... at 1:28 p.m., the Administrator said he did not test the resident when she first came to the facility to see if she could inject the .. . He said he did not arrange to have the .. for Resident #1 administered by licensed nurse. Class I	A 077		
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. , 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 , 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 resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care	A 162		

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A 162	Continued From page 43	A 162		

practitioner's medical examination form described in Rule 59A-36.006, F.A.C.
(c) Any orders for medications, nursing services, therapeutic diets, , 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)(f), F.A.C.
(f) A . ˬ . 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 ˬ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ˬ not be taken.
(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

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A 162	Continued From page 44 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 [illegible] recipient, a copy of the Department of Children and Families form Alternate Care Certification for [illegible] ([illegible]), CF-ES 1006, [illegible], 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 [illegible] of a health care surrogate, health care proxy, 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 [illegible], 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 a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be	A 162		

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A 162	Continued From page 45 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, 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 staff interview, the facility failed to maintain an accurate and complete Resident Record and Resident Agreement for 1 (Resident #1) out of 1 resident reviewed. Failure to obtain and maintain complete records may lead to errors in providing care, billing irregularities, and misunderstandings between the resident or their representative and the facility. The findings included: On , record review showed Resident #1 was admitted to the facility on . The review found no evidence of a Resident Agreement between the facility and the resident or the resident's representative. There was no physician order for or for checking the resident's level. The medication observation record did not document all administrations of . On at 4:22 p.m., the Facility Manager and the Administrator were interviewed. The manager said that, upon admission on , the family provided for the resident. The	A 162		

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A 162	Continued From page 46 manager said the family member instructed the staff to administer 30 units by injection every morning. The manager confirmed there was no prescription from a physician for the . The manager acknowledged it was an error in judgement and she should have obtained orders. She also acknowledged it was an error to accept that was not labeled with resident's name, practitioner's name, date dispensed, name and strength of the drug, directions for use, and expiration date. The Administrator confirmed he did not have the family sign a contract upon admission to the facility. Class III	A 162		