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
	AL11922257	A. BUILDING: _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA GARDENS ALF	701 WEST 9TH STREET RIVIERA BEACH, FL 33404

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A 000	Initial Comments An unannounced Relicensure with Limited Mental Health (LMH), Complaint (#2023012477) and Generator Monitoring survey were commenced on . . . . . and concluded on . . . . . at Victoria Gardens ALF. The facility had deficiencies identified related to the Relicensure, LMH and Complaint #2023012477 at the time of the survey.	A 000		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement	A 032		

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A 032	Continued From page 1 at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and records review, the facility failed to conduct elopement drills twice yearly as required. The findings included:	A 032		

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A 032	Continued From page 2 An interview conducted with Home Health Aide Employee B on . . . . . at 1:12 PM, indicated that Staff B was not informed nor aware of the elopement drill procedure at the facility. Although Staff B claimed to understand what the concept of an elopement drill was when educated on the topic, Staff B affirmed that she has not participated in any elopement drills at the facility. Staff B said that she had been working at the facility for a year and one month. Requests made to review the most recent elopement drills conducted at the facility was to no avail. There was no evidence of the drills in the Staff Training Records. The Administrator was asked to provide evidence of completed elopement drills. She stated that she had not recently completed any elopement drills. No further information was provided for review related to elopement drills during the survey. Class III	A 032		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming	A 052		

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A 052	Continued From page 3	A 052		

that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.
(c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .
(d) Applying , medications.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.
(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .
(4) Assistance with self-administration of medication does not include:
(a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications by way of a tube inserted in a of the body.

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A 052	Continued From page 4 (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally	A 052		

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advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed

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A 052	Continued From page 6 in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that Staff B did not follow the required assistance with the self-administration of medication protocol while assisting 5 of 5 sampled residents (Residents #1, Resident #3, Resident #6, Resident #8, and Resident #10) observed during that task. The findings included: On . . . . . at 12:00 PM, it was noted that Staff B, an unlicensed Home Health Aide who assisted Residents #1, Resident #3, Resident #6, Resident #8, and Resident #10 with self-administration of medications at noon, did not follow the protocol of assistance with the self-administration of medications in assisted living facilities. During the observation of assistance with the self-administration of medication task conducted on at 12:05 PM, Staff B did the following: a) Retrieved the Medication Observation Record (MOR) from the medication cart; b) Meticulously looked for the medications in the medication cart, after checking each resident's name scheduled to receive medications at noon.	A 052		

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A 052	Continued From page 7 c) Staff B prepared all the medications for Resident #1, Resident #3, Resident #6, Resident #8, and Resident #10, and set five cups containing the residents' medications on top of the medication cart. Four of the cups contained pills, and one had a medication in a syrup form. d) Then, Staff B pretended to sign the MOR before proceeding to take the medications to each resident. e) Staff B took the cup containing the syrup, approached Resident #3 and poured the contents in Resident #3's glass of water, without saying what the medication was to the resident. f) Staff B was observed placing in Resident #1's . . . . the pill that was in the medication cup. Staff B did not inform Resident #1 about the pill nor attempted to have the resident take her own medication. g) Staff B did not sign the MOR after each Resident had taken his or her medication. During a briefing with Staff B, thereafter, Staff B was asked if she had an order to dilute Resident #3's medication. Staff B said that she did not have an order, however, Staff B recalled that the resident's Physician had agreed that they mix the syrup with water to encourage absorption of the medication. Staff B did not disagree with any of the observations made. The Administrator was interviewed on . . . . . at 12:39 PM and was questioned about the dilution of Resident #3's medication. The Administrator stated that she did not have an order for that, but she believed that if the resident had mixed the medication with water himself, that would have been fine. Furthermore, during the exit meeting conducted on at approximately 3:45 PM, the	A 052		

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A 052	Continued From page 8 Administrator did not provide any additional information. She acknowledged the factual evidence presented. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (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	A 054		

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A 054	Continued From page 9 medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the Medication Observation Record (MOR) was signed while assisting residents for 5 of 5 sampled residents (Residents #1, Resident #3, Resident #6, Resident #8, and Resident #10) provided with assistance with the self-administration of medications. The findings included: On at 9:00 AM, photographic evidence of the resident's MORs was obtained once at the facility. It was noted that the staff who assisted the residents with self-administration of medications at 7:00 AM and 8:00 AM, had already signed the MORs for medications scheduled for noon, for five residents scheduled to receive medications three times daily. Subsequent interviews conducted on with Residents #1, Resident #3, Resident #6, Resident #8, and Resident #10 thereafter confirmed that they had received their morning medications. The residents said that they also had medications scheduled for noon. During observation of the assistance with the self-administration of medication-self task, on at 12:05 PM, Home Health Aide Staff B was observed assisting the residents. Staff B retrieved the MOR, meticulously looked for the medications in the medication cart after checking each resident's name scheduled to receive medications at noon. Staff B prepared all the medications for Resident #1, Resident #3, Resident #6, Resident #8, and Resident #10, and set all five cups containing the residents'	A 054		

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A 054	Continued From page 10 medications on top of the medication cart. Then, Staff B pretended to sign the MOR before proceeding to take the medications to each resident. After completing the task, Staff B was briefed about the observations made: 1) Staff B had failed to sign the MOR after assisting residents with self-administration of medications (as observed). 2) Staff B had already signed the MOR before beginning to assist residents with self-administration of medications during the noon task. 3) When presented with the evidence, Staff B did not refute the observations. The findings were discussed with the Administrator during the exit meeting conducted on at approximately 3:45 PM and she acknowledged the findings. Class III	A 054		
A 152 SS=E	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following	A 152		

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A 152	Continued From page 11 furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [illegible] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [illegible] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [illegible]. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that the facility did not maintain an environment free of hazard, perform necessary repairs in a timely manner, and offer a homelike environment for 17 out of 17 residents residing in the facility. The findings included: On [illegible] at 9:13 AM, the following environmental concerns at the facility were noted: a) The common living area had multiple areas of the walls that were broken, had peeling paint, unsecured door frames, and an uncovered light switch.	A 152		

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A 152	Continued From page 12 b) The toilet seat in the blue bathroom did not fit the circumference of the toilet bowl. The ceiling had peeling paint above the shower section and was noticeably leaking. The AC vent on the ceiling was clouded with dirt which extended onto the area of the vent. c) The bathroom sink in the white bathroom was clogged up, the water was not draining. d) The light fixture above the sink in the brown bathroom was heavily rusted. e) The kitchen sink was also leaking. A bucket was placed under the sink to retain the dripping water. The bucket containing the dirty water was half full. f) The closet door in the bedroom adjacent to the white bathroom was unhinged. It was haphazardly placed in the closet track. One of the residents motioned that it has been that way for a while. The wooden flooring had caved-in tiles which created an uneven surface and a trip hazard. g) Resident #3 and Resident #4's bedrooms had holes in the ceilings. h) The backyard area where some of the residents smoke was unkempt, with debris, untrimmed tree branches, and leaves all around. The cemented walkway had green algae looking buildup; the area was not homelike. The findings were discussed with the Administrator via telephone during the exit conference conducted on at approximately 3:45 PM. Class III	A 152		
AL243 SS=D	429.075(1) FS; 59A-36.011(9) FAC LMH - Training	AL243		

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AL243	Continued From page 13 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. This designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training must be provided by or approved by the Department of Children and Families. 59A-36.011 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S.,	AL243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922257	A. BUILDING: _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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AL243	Continued From page 14 and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement. (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by:	AL243		

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AL243	Continued From page 15 Based on record review and interview, the facility failed to ensure completion of the required Limited Mental Health (LMH) training for 3 of 3 sampled employees (Staff A, Staff B and Staff C). The findings included: Review of the Staffing Training Record on [redacted] revealed that Staff A (the Administrator), Staff B, and Staff C both Home Health Aides, did not complete the minimum of 3 hours of continuing biennial education, in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (I) Mental health needs, services, behaviors and appropriate interventions; (II) Resident progress in achieving treatment goals; (III) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, ( ) Crisis services and the [redacted] procedures. Review of Staff A's personnel record revealed a date of hire of [redacted]. Further review revealed the last documented LMH training completed was on [redacted] (3 Hours). Staff B was observed at the facility performing regular duties on the morning shift of [redacted]. Staff B reported during an interview conducted on [redacted] at 1:11 PM that she has been working at the facility for a year and one month. Review of the personnel record revealed a date of hire of [redacted] with no evidence of LMH training conducted since the date of hire. Staff B confirmed that she did not complete the LMH training.	AL243		

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AL243	Continued From page 16 Review of Staff C's personnel record revealed a date of hire of . . . . . Further review of the personnel record revealed no evidence of LMH training since the date of hire. The Administrator stated on . . . . . at 3:30 PM that she did not realize that it was already time to complete the training. She admitted that none of the sampled employees selected had completed the LMH training. The Administrator said that she will do it as soon as possible. Class III	AL243		