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
	AL11968848	A. BUILDING: _____ B. WING _____	10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORSELIFE MEMORY CARE RESIDENCE	4847 FRED GLADSTONE DR WEST PALM BEACH, FL 33417

(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 Complaint survey (#2023014646 and #2023015285) was conducted on and concluded on at Morselife Memory Care Residence. The facility had a deficiency identified related to Complaint #2023014646 at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure adequate supervision was provided to a resident residing in the Memory Care Unit for 1 of 1 sampled resident (Resident #1). The facility also failed to maintain written documentation of significant behavior changes for, 1 out of 1 sampled resident records reviewed (Resident #1). The findings included:	A 025		

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A 025	Continued From page 2 In an interview conducted with the Administrator Staff N on at 2:15 PM, a request was made for the facility's Supervision Policy. She stated the 4-page Resident Care policy that is part of the Admission Packet constitutes the facility's Policy on Supervision. A review of the facility's 4-page Resident Care Policy (Policy and Procedures Manual) with a revision dated of documented the following: Memory Care at Morselife will offer personal supervision as appropriate for each resident. The Memory Care Director will be responsible with her staff to provide daily observation of the activities of the resident while on the premises and daily awareness of the general health, safety, and physical and emotional well-being of the individual. Memory Care at Morselife will offer personal supervision, as appropriate for each resident, including general awareness of the resident's whereabouts. Memory Care at MorseLife will maintain a written record, update as needed, of any significant changes in the resident's normal appearance or state of health, any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provisions of additional services. A review of Resident #1 facility's file documented that she was admitted to the facility Memory Care Unit (MCU) on and was discharged on (family removed the resident from	A 025		

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A 025	Continued From page 3 the facility). A review of Resident Health Assessment (AHCA Form 1823) dated documented her diagnosis as: , , and High . Her . Status is very forgetful, gets angry at times. A review of Resident #1's AHCA form 1823 dated documented her diagnosis as Abnormal loss, COVID Coronavirus, Moderate , , and . Status as: of the 's Type with behavioral disturbance, Primary degenerative of the 's type, Onset, with behavioral disturbance. A review of the Resident #1's AHCA form 1823 dated documented her diagnosis as: Abnormal loss, Moderate , , and . Status as: of the 's Type with behavioral disturbance. A review of the Resident #1's AHCA form 1823 dated documented her diagnosis as: Abnormal loss, , Moderate , , and . Status as: of the 's Type with behavioral disturbance. A review of a statement from a Private Duty Aide (PDA) dated documented the following: On between 1:50 PM and 1:55 PM she was passing Resident #1's room and observed that the door to Resident #1's room was cracked open. When observing the door set like this and being music time on the 2nd floor that	A 025		

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A 025	Continued From page 4	A 025		

Resident #1 enjoys, she pushed the door following her peaking in the room to see Visitor #1 pecking Resident #1 on the . . . while standing next to her bed by the door entrance. She stated she stood outside the door, stating what are you doing?! Causing Resident #1 and Visitor #1 to jump flustered removing their . . . from one another's private parts in their pants. PDA then asked Resident #1 to come with her, and Visitor #1 then proceeded to state, "I'm sorry!" in a frightened tone. Then Resident #1 came with me to bring her to the elevator to to music. Visitor #1 left the Memory Care through the entrance doors. She asked Resident #1 if she was okay, Resident #1 stated "I'm okay." She then proceeded to sit for music. PDA then came to Memory Care Director Staff O's office, then to Assistant Memory Care Coordinator Staff L's office as she was not able to find each of them during that time. She then went to see Director of Housekeeping Staff J, directly to inform her of the incident that she observed.

Prior to this incident, the PDA documented that she had seen Visitor #1 and Resident #1 in common areas and outside interacting, however she thought Visitor #1 was her husband. They were always just talking not interacting in a touching way, when observed yesterday was concerning and had an intuition that something was not right. Based on Visitor #1's reaction when confronted, he also was defensive.

In an interview conducted on at 8:42 AM with the PDA, she stated that she was the witness to an inappropriate incident involving Resident #1 and Visitor #1. She stated on at approximately 1:30 PM she walked by Resident #1's room on the first floor of the Memory Care Unit (MCU) and noticed her door

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A 025	Continued From page 5 was halfway open. She stated she knocked on the door, pushed it open and was preparing to ask Resident #1 to join the activities on the second floor, as she had done on previous occasions. She stated that upon pushing the door open, she saw both Resident #1 and Visitor #1 in a standing position with their in each other's pants through the zipper area of the pants. The PDA further stated in the interview at 8:47 AM on that both Resident #1 and Visitor #1 were both startled when she entered the room, and she started to tell Visitor #1 in a loud voice you are sick, and to leave the room as he had no business being in her room. She stated after Visitor #1 left the room, she went looking for Assistant Memory Care Coordinator Staff L and Memory Care Unit Director Staff O and the shift nurse (unnamed) but was only able to find the Director of Housekeeping Staff J, so she reported the incident to her. Observation of the Memory Care Unit (MCU) on at 2:18 PM by this surveyor revealed that upon entry into the MCU there is an open activity/dining area in front to the right, and a kitchen area just left (North) of it. Observation was also made of the rooms where Resident #1 resided, and Resident #2 resided. To access Residents 1 and 2 rooms, staff or visitors would pass between the open activity/dining area to the right and the kitchen area that is left (North) of the dining area and proceed down the hallway. At the time of the incident Resident #1's room was located three doors from Resident #2's room on the same (North) side to the hallway. So, staff or a visitor would pass Resident #1's room prior to getting to Resident #2's room on the first floor. A review of the facility's staff schedule for	A 025		

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A 025	Continued From page 6 . . . . . documented the following direct care staff was scheduled for the 7:00 AM to 3:00 PM (the shift in which the incident occurred) was Certified Nursing Assistant (CNA) Staff K, CNA Staff M and CNA Staff H. Director of Housekeeping Staff J was also present in the MCU but does not provide direct care. The direct staff present on the first floor of the MCU stated during interviews that they were unaware of the incident taking place in Resident #1 room. In an interview conducted with CNA Staff H on . . . . . at 2:28 PM, she stated she has been at the facility for 8 years and provides direct care for residents. She stated they have three staff on each shift and a nurse 8:00 AM to 8:30 PM. She stated Visitor #1 comes several times a week to visit his wife Resident #2, who is in the MCU. She also stated staff checks on residents every 2 hours. Staff H stated she was not aware of the incident at the time it was occurring and could not remember where she was/or was doing at the time of the incident. In an interview conducted with Licensed Practical Nurse (LPN) Staff I on at 2:41 PM, she stated visitors can visit residents in common areas, their rooms, etc. from 8:00 AM to 8:00 PM and they have access badges. She stated there are 3 CNAs on each shift and 1 LPN from 8:00 AM to 8:30 PM daily. She stated staff is to check on residents every 2 hours, and visitors are monitored by CNAs and nurses. She stated she never saw Resident #1 interacting with a visitor, and that she would always tell people "Get away from me." She further stated in the interview that Visitor #1's wife (Resident #2) is still at the facility, and that he comes and visits her during mealtimes and assists with feeding her. She stated prior to her decline he would come into the	A 025		

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A 025	Continued From page 7	A 025		

dining room and feed her. When she started declining, he would feed her in her room. She stated that when Visitor #1 came into the MCU (prior to the incident), he would greet them first, and go unescorted to his wife, Resident #2's room. Staff I stated she was not aware of the incident at the time it was occurring.

In an interview conducted with Director of Housekeeping Staff J on at 11:58 AM, she stated that a caregiver was in the MCU and came into her office on the second floor and told her about the incident involving Resident #1. She stated the caregiver told her she was looking for Memory Care Director Staff O, but she was not there, and she wanted to talk to someone else. She further stated the PDA came into her office and she said she needed to tell her something. She stated the PDA informed her Visitor #1 was in the room of Resident #1 with his inside her pants. She further stated Resident #1 could not express her needs and had never done anything inappropriate before. Staff J stated she was not aware of the incident at the time it occurred but was notified by the PDA afterward.

In an interview conducted with CNA Staff K on at 12:15 PM, she stated that she has worked at the facility for several years and works the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts. She stated Resident #1 was compliant with her medications, would , could not talk very well, and would make her needs known by nodding at questions. She stated she would go out on the garden patio on the second floor and sit by herself. She stated she never saw her sitting with anyone while out there, and that she was not aware of the incident at the time it occurred.

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A 025	Continued From page 8 In an interview conducted with Assistant Memory Care Coordinator Staff L on at 3:05 PM, she stated there is a 1 to 8 ratio of staff to patients, with 3 CNAs on each shift, along with an LPN on both the first and second floors from 8:00 AM to 8:00 PM. Relative to visitation, she stated visitors can come and go to their family members room, the garden area, and can move about the unit freely. She also stated Resident #1 was independent, hostile, a fighter, did not want to be told what do, will fight when time to take showers (sometimes takes up to 6 people to shower her), can verbalize her needs, had moderate to severe , her recall is incoherent, and her short-term memory was very short. She stated the resident would do something to you and forget the next minute; and that she knows what she is doing in the moment. She stated the resident could make her needs known to an extent, but only did what she wanted to do. Assistant Memory Care Coordinator Staff L also stated in the interview on at 3:09 PM, that Resident #1 was found in a male resident's room having , and that she was very , active and that it was reported to the Memory Care Unit Director Staff O (no time/or date provided). A review of the Resident's facility file and documents did not reveal any documentation of the behavior/or actions. She also stated the residents have arm that allow her/them to go onto the computer and know exactly where every resident is. She stated they do not provide 1-on-1 care, the resident doors lock but the resident does not know how to, and they do not lock them unless it is requested. She stated Resident #1 was the initiator of the and would openly talk about men and their peers. She stated the resident was one of the highest functioning residents, and other residents found her	A 025		

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A 025	Continued From page 9 intimidating. However, she was not a witness to the incident involving Resident #1 and Visitor #1 on [redacted]. Assistant Memory Care Coordinator Staff L further stated in the interview on [redacted] at 3:12 PM, that at the time of the incident on [redacted] she was in the MCU conducting an interview on the second floor. The incident took place on the first floor. She stated it was brought to her attention by the PDA and Director of Housekeeping Staff J. She stated the Director of Housekeeping Staff J told her that Resident #1 was touching Visitor #1 inappropriately, and Visitor #1 was touching Resident #1 inappropriately. In an interview with the Administrator/SVP Staff N on [redacted] at 2:28 PM she was not aware of the actions (provided to this surveyor by the Assistant Memory Care Coordinator Staff L). No documentation of the stated behavior/or actions by Resident #1 was available or provided during the survey. In an interview conducted with CNA Staff M on [redacted] at 3:08 PM, she stated that she works on the first floor and that all staff are assigned to residents and that Resident #1 was assigned to a different employee. She stated Resident #1 liked to flirt around with other residents. She stated she could not recall if she did so with visitors, but that she never saw her with Visitor #1. She stated she did have some other resident (she was active with) that lived on the second floor; they used to talk a lot. She did not state if she reported the incidents/or to whom. CNA Staff M further stated she did not see anything out of the normal the day of the incident and was not aware of the incident at the time it was occurring. In an interview conducted with Administrator Staff	A 025		

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A 025	Continued From page 10 N on [redacted] at 11:55 AM, she stated that Resident #1 cares for herself for the most part, walks with a walker, she seems to get along well with the other residents and staff, is capable of making her needs known, but did not think she can make decisions. During a further interview conducted with Administrator/Senior Vice President (SVP) Staff N on 12:05 PM, she stated that Resident #1 appears to be quiet, can be forgetful and she did not think Resident #1 could make her needs known. She stated Resident #1 resides on the 1st floor and would come up to the 2nd floor to participate in activities, but never sits still, and is usually around the floor. In a telephone interview conducted with LPN Staff Q on [redacted] 1:15 PM, she stated to the surveyor that Resident #1 would be very outgoing and talked to other residents, and that she had limited capacity. She stated she could make her needs known, but was not capable of making her own decisions, and she would just walk around the unit. In an interview conducted with Registered Nurse (RN) Staff P on at 1:35 PM, she stated that Resident #1 liked to talk to a lot of people and would have good days and bad days. She stated the resident usually would be very outgoing in the mornings and sometimes she would get angry or upset in the afternoons and use some foul language at times. She stated Resident #1 could make her needs known for the most part and could be very , and at times she would sneak into other residents' rooms and take small items that did not belong to her. She further stated Resident #1 would climb into the bed of the male resident directly across	A 025		

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from her room (now . . . . .) and the resident would complain about it. She stated Resident #1 would make statements that she had a boyfriend on the 2nd floor and would approach male visitors on the unit and smile at them. She stated it was reported/known to the Memory Care Unit Director Staff O (No date/or time was provided). No documentation of the stated behavior/actions by Resident #1 was available or provided during the survey.

In an interview conducted with the Administrator/SVP Staff N and Assisted Living Director Staff P on at 9:43 AM, the Administrator Staff N stated that after the incident Resident #1 did not require being sent out for any additional evaluations, and there was nothing more to be done than what they did. She stated the resident was not undressed or anything, so no assessment was done by the nurse, as based on the witness statement, no one was undressed, and nothing abnormal was reported. She also stated that there was no . . . . or anything on Resident #1. She stated because Resident #1 was high functioning, the CNA says that she yells when she gives her showers as she does not like them. So, if she had yelled, they would have escalated (the incident) to her Physician, but she did not, and Resident #1 was not upset.

In an interview with the Administrator/SVP Staff N and Assisted Living Administrator Staff P on . . . . . at 10:01 AM, Staff N stated Visitor #1 was a resident in their Independent Living section. She stated that as soon as the incident was reported, she and the Executive Director went to the Independent Living building to speak with Visitor #1. Staff N stated Visitor #1 told her that he didn't think he was doing anything wrong because Resident #1 liked him, and that she

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walked him into the room, they sat on the bed and started talking. Staff N stated she asked Visitor #1 if anything happened, and he said he didn't remember, and that the door was open the whole time. The Administrator/SVP provided this surveyor a copy of Visitor #1's verbal statement in which she documented per their conversation for review. However, there was no additional documentation (i.e., facility incident report) provided during the survey.

In an interview with the Administrator/SVP and Assisted Living Administrator Staff P on at 9:43 AM, she stated she informed Visitor #1 that Resident #2 was going to be moved to another floor (2nd) and he would have to contact the Memory Care Coordinator Staff O to let her know the days and time he was coming, and staff would have to let him in. She stated they do not personally escort him to Resident #2's room. She stated there is staff on the floor and Visitor #1 isn't supposed to go to anyone else's room, and that is there to visit Resident #2. Staff N further stated there was no guilty charge, based on his actions, Resident #1 was participating, so she didn't think that she had to restrict his visits.

In an interview conducted with Administrator/SVP Staff N and Assisted Living Administrator Staff P on at 2:31 PM, she stated [name of the Risk Management software used by the facility] requires that a step-by-step process take place in the event of an incident. And that the system will prompt a response, move to the next question, etc., based on the information that is entered. She stated the CNA on the floor will fill out the questionnaire and the Nurse on the floor will enter the information into the system. She stated there was no entry for this resident as they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968848	A. BUILDING: _____ B. WING _____	10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORSELIFE MEMORY CARE RESIDENCE	4847 FRED GLADSTONE DR WEST PALM BEACH, FL 33417

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 025	Continued From page 13 determined there was no negative impact to the resident. As such, no facility incident report documenting the incident was completed, and made available during the survey. In a telephone interview conducted with a family representative for Resident #1 on [redacted] at 3:26 PM, the representative stated that the incident caused Resident #1 a considerable amount of distress and that she had to be moved to another facility after the incident because staff stated she was being a challenge. She stated Resident #1 was super [redacted] and did not understand why she was moved and was wondering if she did something wrong. In an interview conducted with Administrator/SVP Staff N on at 2:15 PM, she stated Resident #2 was moved to 2nd floor and Visitor #1's access badge/card was taken away and destroyed. He could only enter the unit upon access granted by staff member on duty. Further investigation of the facility's Memory Care Unit's 2nd floor by this surveyor on [redacted] at 3:18 PM revealed a visitor (or staff) without an access badge would have to be buzzed into the unit and take the elevator located to the left (North), to the MCU's second floor. The elevator does not require a pass key/code to gain access to the second floor. After exiting the elevator, the Assistant Memory Care Unit Coordinator's office is located directly across from the elevator. The visitor/or staff would exit to the East and then have access to the open activity area (where activities take place), resident rooms and the outside patio area. Observation of Resident #2's revealed a visitor would pass the open activity area and several resident rooms prior to reaching it. In an interview with the Administrator/SVP on	A 025		

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
	AL11968848	A. BUILDING: _____ B. WING _____	10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORSELIFE MEMORY CARE RESIDENCE	4847 FRED GLADSTONE DR WEST PALM BEACH, FL 33417

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A 025	Continued From page 14 . . . . . at 2:17 PM she stated Visitor #1 continues to visit Resident #2 unsupervised. In the interview conducted with the Administrator/SVP and Assisted Living Administrator Staff P on at 2:18 PM, she stated there was no training or follow-up training for staff after the incident, or any new policy procedure put in place following the incident. No documentation of follow-up to Resident #1's family to address their continued safety and supervision concerns was available/or provided during the survey. Nor was any documentation of the corrective action(s) taken, or process/procedures put in place designed to circumvent future occurrences from occurring were provided during the survey. Class III	A 025		