Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966084	A. BUILDING: _____ B. WING _____	10/23/2023

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TITUSVILLE TOWERS	405 INDIAN RIVER AVENUE TITUSVILLE, FL 32796

(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 A re-licensure survey and revisit was conducted on . . . . . at Titusville Towers. Deficiencies were found at the time of the visit.	A 000		
A 010 SS=D	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, 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	A 010		

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A 010	Continued From page 1 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 applicable department. (3) A physician, physician assistant, or advanced	A 010		

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A 010	Continued From page 2 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 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care	A 010		

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A 010	Continued From page 3 practitioner, the resident must be discharged from the facility. (c) A [redacted], 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 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:	A 010		

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A 010	Continued From page 4 Based on resident record review and interview, the facility failed to obtain a new 1823 Health Assessment for 1 of 5 sampled residents (#7) for a significant change for multiple , as a precaution completed by the healthcare provider as required. Findings: Resident #7 record review revealed admission date . The last 1823 Health Assessment dated listed medical history of , and affecting left non-dominant side, /Idiopathic , Major D deficiency, Essential and change in habit. Resident #7 ambulates via wheelchair and has a rail hospital bed for safety in her bedroom. She needs assistance with activities of daily living (ADLs) with bathing and . Total care for ambulating. Independent in eating, grooming and toileting. She needs assistance with self-administration of medications. Resident #7 is not on Hospice care. (Photographic Evidence Obtained) Resident #7 has had seven (7) since admission into the facility, without any injuries as follows: 1. 2. 3. 4. 5. 6.	A 010		

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A 010	Continued From page 5 7. . . . . . There was no new updated 1823 Health Assessment completed by the healthcare provider notating a special precaution for high risk of . On at 2 PM, an interview with the Assisted Living Manager confirmed the findings. Class III	A 010		
A 025 SS=D	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	A 025		

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A 025	Continued From page 6 services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as prescribed by a health care practitioner to 1 of 8 sampled residents who required assistance with medications (#17). Findings:	A 025		

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A 025	Continued From page 7 A review of resident #17's health assessment form (1823) revealed the resident required assistance with self-administration of medications. The resident's medical history included and . A facility medication management/observation error report indicated the resident was not given her 8 pm , and Rosuvastatin on . A review of the resident's , Medication Observation Record (MOR) revealed med tech D signed that she gave the medications. On at 1:25 pm, the clinical supervisor said she learned of the med error because the resident said on that she did not receive her 8 pm meds on the night before. The clinical supervisor said when she questioned med tech D, the med tech confirmed the medications were not given. On at 1:30 pm, med tech D initially said she could not recall specifics related to the meds not being given. She said the MOR was probably signed because she signs it when she prepares the meds. She said she knows the MOR is to be signed after residents take their meds. She then said she went twice to try to give the resident the medications but the resident was unavailable both times. On Med tech D received 6-hours of training on providing assistance with self-administered medications. Class III	A 025		

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A 052	Continued From page 8	A 052		
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 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	A 052		

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A 052	Continued From page 9 dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (4) Assistance with self-administration of medication does not include: (a) Mixing, [illegible], converting, or [illegible] 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 [illegible] of the body. (d) Administration of [illegible] preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] 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.	A 052		

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A 052	Continued From page 10 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 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,	A 052		

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A 052	Continued From page 11 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 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 record review and interviews the facility failed to follow proper medication - assistance with self-administration by an unlicensed staff C for 1 of 1 sampled resident. Findings: On . . . . . at 12:53pm During Staff C's interview it was stated there is a resident who requires . . administration. On at 12:53pm Staff C stated, "I provide assistance to resident #18."	A 052		

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A 052	Continued From page 12 On at 12:53pm Staff C stated, "yes, I'm dialing the . . I usually just turn it to the number." On at 12:53pm Staff C stated, "yes, I know I should not be dialing. I have received training on medication self-administration." In review of Staff C's record revealed a document signed and dated on stating, Resident - CNA's cannot do the following: removing the cap on the , placing the needle on the end of the and screwing it on to secure it, calibrating the dose by turning the end of the to the correct number (if vision , resident may ask the CNA to verify that resident has dialed the correct dose), and administering the dose in designed area. It is required by law that all residents who use must complete these steps for assisted self-administration." On at 12:53pm Staff C stated, "resident #18 is able to do it themselves. I think she just doesn't want to do it." On at 12:53pm Staff C stated, "yes, I am telling resident #18 the name and dosage of everything." On at 1:33pm Resident #18 stated, "I'm able to dial my pen myself, but the med tech does it for me." On at 1:33pm Resident #18 stated, "whatever" when informed the med techs are no longer able to dial for her. Review of the facility's policy and procedures	A 052		

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A 052	Continued From page 13 medication practices dated , states assistance with self-administration does not include the preparation of syringes for injection or the administration of medications by an injectable route. On at 2:53pm The Clinical Nurse stated, "I am unaware that the med techs are dialing resident #18's ." On at 2:53pm The Clinical Nurse stated, "the staff knows there not to dial the ." On at 2:53pm The Clinical Nurse stated, "I have no idea if resident #18 dialed before and if resident #18 can do it." Review of Resident #18's Medication Observation Record (MORs) revealed on , - , , , , - , , , and . The MORs legend indicates 2 = drug refused. Review of facility's policy and procedures medication practices dated , states, "unsafe reaction or noncompliance must be reported to the nurse who will report this to the Health Care provider and document in the resident's record." On at 2:53pm The Clinical Nurse stated the doctor is aware that resident #18 is refusing the medication. The Clinical Nurse stated I'll have to contact the doctor to see if she has notes. She does not keep the notes on file here".	A 052		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 052	Continued From page 14 Review of Resident #18's MORs revealed on [illegible]. The MORs legend indicates 4 = BS/Vitals Outside of Parameters for Administration. On [illegible] at 2:53pm The Clinical Nurse stated, "most of the time when it's over the staff contacts me at home when I'm on call. I contact the doctor even on Saturday and Sunday." On [illegible] at 2:53pm The Clinical Nurse stated, " I do not update resident #18's chart. I don't get on the computer to update the chart." On [illegible] at 2:53pm The Clinical Nurse stated, "no, I don't follow the policy by documenting it in resident #18 chart. On [illegible] at 2:53pm The Clinical Nurse confirmed the findings. Class III	A 052		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966084	A. BUILDING: _____ B. WING _____	10/23/2023

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A 055	Continued From page 15 locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration	A 055		

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A 055	Continued From page 16 of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, resident record review and	A 055		

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A 055	Continued From page 17 interview, the facility failed to centrally store, kept in a locked cabinet for prescription medication for 1 of 5 sampled resident (#7). Findings: Observation on at 10:45 AM, an over the counter (OTC) bottle was found in resident #7's room and was not centrally stored and locked safely. (Photographic Evidence Obtained) Resident #7 record review revealed admission date . The last 1823 Health Assessment dated listed medical history of and affecting left non-dominant side, /Idiopathic , Major D deficiency, Essential and change in habit. Resident #7 ambulates via wheelchair and has a rail hospital bed for safety in her bedroom. She needs assistance with activities of daily living (ADLs) with bathing and . Total care for ambulating. Independent in eating, grooming and toileting. She needs assistance with self-administration of medications. Resident #7 is not on Hospice care. On at 10:45 AM, an interview with resident #7 while she was sitting in her lift chair with a patch on both . The resident was asked what the patches were used for, and she answered patches when her begin to hurt, she asks to put them on. It was seen that several bottles of was in	A 055		

Agency for Health Care Administration

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A 055	Continued From page 18 the apartment and when asked, resident #7 stated that she had an order from her doctor to have the [redacted] in her room. It was explained that we must double check since she says she needs assistance with medication. There were no orders found in resident #7's record to self-administer her own [redacted]. The orders found to self-administer her own medications were [redacted] 81 milligrams and [redacted] powder dated [redacted]. On [redacted] at 1:45 PM, an interview with the Clinical Supervisor confirmed the findings. Class III	A 055		