Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969444	A. BUILDING: _____ B. WING _____	12/14/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation survey (Complaint numbers 2023017500 and 2023016250) was conducted at Plaza at Parksquare from . . . . . through . . . . . Deficiencies were identified at the time of the survey.	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,	A 010		

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A 010	Continued From page 1 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 applicable department.	A 010		

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A 010	Continued From page 2 (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 record; and,	A 010		

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A 010	Continued From page 3 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 holding an extended congregate care license are	A 010		

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A 010	Continued From page 4 described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the continued appropriateness of residence and follow its own admission and discharge policy for one out of fifty-nine sampled residents that required 24-hour [redacted] care (Resident 22). Findings include: Observation on [redacted] at approximately 8:15 AM showed Resident 22 was in the second-floor dining area accompanied a Private Duty Aide (PDA) Further observation showed that Resident 22 was visibly agitated, exhibiting constant chatter, clinging on to her PDA and pinching her on the side. Interviewed on [redacted] at approximately 8:18 AM Resident 22's PDA stated that the Resident needed 24-hour care. The PDA stated, "She can't be left alone at any time." The PDA also stated that she worked 12-hour shifts, and two other PDAs were assigned to the Resident at different shifts. A review of the facility's admission and discharge criteria showed the following, "Shall accept only those persons whose needs can be fully met by the existing staff, physical environment and services already provided. The assisted living residence's ability to meet residents' needs shall be based upon a comprehensive pre-admission assessment (Resident Health Care Assessment for Assisted Living Facilities- AHCA Form 1823) of a resident's physical, mental, and social needs; cultural, religious and activity needs; preferences; and capacity for self-care." Further review of the	A 010		

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A 010	Continued From page 5 facility's Admission and Discharge criteria showed the following, "Will screen any potential admissions for the following criteria, "Is profoundly disoriented to time, person and place with safety concerns that require a secure environment, and the facility does not provide a safe environment. The assisted living residency shall arrange to discharge any resident who: (E) Is profoundly disoriented to time, person and place with safety concerns that require a secure environment, and the assisted living residency does not provide a secure environment." (F) Exhibits conduct that poses a danger to self or others and the assisted living residence is unable to sufficiently address those issues through therapeutic approach, and/or (G) Needs more services than can be routinely provided by the assisted living residency or an external service provider." A review of Resident 22's health assessment dated showed that Resident 22 required 24-hour care. Further review showed diagnoses of and . The status showed alert and disoriented. The Resident's ADL (Activities of daily living) evaluation showed she needed assistance with ambulation, bathing, eating, self-care, toileting and transferring. Interviewed at approximately 9:54 AM when asked about Resident 22's need for 24-hour care the Administrator stated, "She has a PDA because her husband wants her to always have a companion." Class III	A 010		

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A 025	Continued From page 6	A 025		
A 025 SS=H	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) 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.	A 025		

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A 025	Continued From page 7 (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 maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention for eight (#1, #16, #17, #21, #22, #29, # 30, #37) out of 88 sampled residents. Findings: 1) A review of Resident #29's nurse's notes dated . . . . . showed that the resident was incoherent and had a , of . Further review found no documentation that the primary care physician was called. The nurse's notes dated . . . . . showed: "Resident had "episode" as per med tech and CNA. Med tech called for LPN on radio when nurse arrived. Resident was incoherent. ."	A 025		

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A 025	Continued From page 8 Interviewed on at 1:26 AM the Director of Nursing Care stated that Resident #29 did not but had like symptoms. Reviewed nurse's notes dated for Resident #29 showed: "Resident sent to hospital due to possible and ." Reviewed Resident #29's health assessment dated showed diagnoses of II, history of purpura (ITP), The status showed awake, alert and oriented times three and forgetful at times. The resident had a precaution. The resident's activities of daily living showed assistance needed with ambulation, bathing, self-care, toileting, transferring and supervision needed with eating. 2) Interviewed on at 12:30 PM the Daughter of Resident #17 stated, "He twice in one month, I was there the second time he because I manage their medications. It was , I went downstairs for a [store] package, and he . He did not go to the hospital, he did not have to, there was nothing broken. The Director of Nursing (DON) in right away. He assessed him." The daughter stated, [the DON] evaluated him and that there was no need to call rescue or to send him to the hospital. They arranged for the care and in-house." I agreed because I don't like hospitals and emergency rooms, they did not treat him very well there the last time." A review of Resident #17's nurse's notes showed	A 025		

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A 025	Continued From page 9 no documented for or primary care physician notified. There was no documentation that an evaluation, care or was ordered by the physician. Reviewed Resident 17's health assessment dated showed diagnoses of normal pressure , , physical limitations of gait and balance, the use of a walker and wheelchair for long distances, mild , , no nursing/treatment, or , requirements were indicated. The resident had a precautions. The ADL (Activities of Daily Living) assessment showed he was independent with ambulation, , eating, self-care, toileting, transferring and required assistance with bathing. Observation on at 12:20 PM Resident #17 walked with a limp and was assisted by Private Duty Aide coming out of the bathroom. Interviewed on at 12:15 PM Resident #17's wife stated that her husband two or three times. The wife stated further, "He broke his and his arm, two or three months ago, he's ." Interviewed on at 12:25 PM the Private Duty Aide for Resident #17 stated, "I was not here when he . He tried to get up from the chair. Rescue was not called. He did not go to the hospital 3) A review of Resident #22's nurse's noted showed resident had a on . However, there was no documentation that the primary care physician was notified.	A 025		

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A 025	Continued From page 10 A review of facility records for Resident 22 dated at 8:30 pm showed, "Resident in her room under the care of the private aid when she was changing her clothes, she lost her balance and hit her with the dresser; open noted on forehead cm, needs to be sutured in ER. The Resident was transferred by family to hospital for evaluation. Cleaned and applied gauze and tape." Follow up required by the hospital for and probable concussion. Reviewed Resident #22's Health assessment dated showed diagnoses of The resident needed assistance with ambulation, bathing, grooming, eating, toileting, and transferring. The resident Required 24-hour nursing or care. 4) A review of Resident #37's nurse's notes showed the following: "Notified by MedTech that Resident was found sitting on the floor. Resident assessed, no or observed, no complaint of . Skin intact. Monitoring continues. Received call, staff reports that Resident was sitting by computer with on his shirt, and also noted on the floor. Observed playing a game on the computer. When asked what happened replied, 'I went to get up and by the bed then I went to the bathroom to wash up and then I came here to sit and play a game' Resident noted to (R) side of the forehead over the approximately 1" in length. Pressure was applied to the area, 911 was activated and Resident was transported to ER at [hospital] for evaluation and treatment. Son made aware." Further review found no documentation	A 025		

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A 025	Continued From page 11 that the primary care physician was called. Interviewed on [illegible] at 10:45 when asked why Resident #37 had a [illegible], the Private Duty Aide (PDA) stated that he had it since his last [illegible]. The PDA stated further, "He's had that cut over his [illegible] since he [illegible] about 2 months ago. His son now had PDAs around the clock with him since he [illegible]. He is 93, he [illegible] 3 times, the last time was about 2 months ago. Yes, it was in [illegible]." The PDA stated, "It happened at night, I wasn't here. He hit his [illegible] and [illegible] a lot. No, he did not have a pendant, now he has one. The staff make rounds every 2 hours and they found him on the floor in the bedroom, apparently, he was going from the bed to the bathroom. He went to the [hospital] and to rehabilitation. The other [illegible] were before I started taking care of him. He used to walk but started to lose his stability, his [illegible] gave out." A review of Resident #37's health assessment dated [illegible] showed diagnoses of [illegible]'s [illegible], Angioplasty, History of [illegible]. The [illegible] status showed [illegible] and [illegible] decline due to patient diagnostic. The resident had a risk for a high [illegible] precaution. The resident needed assistance with ambulation, bathing, [illegible], self-care, toileting, transferring, but needed supervision with eating. 5) Interviewed on [illegible] at 10:17 AM when asked about Resident #21 receiving rough handling from staff related to her not wanting to shower, the Director of Nursing Care stated, "They're supposed to inform me about her. It depends on the person giving her the shower.	A 025		

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A 025	Continued From page 12 No, we don't have a plan for the resident to get a bath every day. No, we don't write down everything. The supervisor is supposed to go into the room." However, there was no documentation that resident #21 refused to take daily shower including notifying the primary care physician. In addition to the shower, Resident #21 had a on . There was no documentation that the primary care physician was contacted about the concern. A review of Resident #21's health assessment dated showed diagnoses of , , , , . The physical or sensory limitations showed . The or behavioral status showed . The nursing/treatment/ service requirements stated memory care. The resident had special precautions. The resident's activities of daily living showed independent in ambulation, bathing, , eating, self-care, toileting, and transferring. 6) A review of Resident #30's nurse's notes dated showed, "Resident reported he inside apartment in bedroom area he was observed with at left , left , and hematoma at left . [Daughter] and wellness director notified." There was no documentation that Resident #30's primary care physician was notified. A review of Resident #30's health assessment dated showed diagnoses of , , HLD, Tinnitus, Tremors. The physical limitations showed he used a walker for long distances. The status showed alert and oriented times three. The	A 025		

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A 025	Continued From page 13 nursing/treatment/ , , , service requirements showed "N/A". The resident had a precaution. The resident's activities of daily living showed independent in bathing, , eating, self-care, toileting, transferring, and supervision with ambulation and transferring. 7) A review of Resident #55's nurse's notes showed the resident had a on . However, there was no documentation that the primary care physician was called. A review of Resident #55's health assessment dated showed , 's , Hard of Hearing, and . The resident did not have a precaution. The resident's activities of daily living showed independent in ambulation, , eating, self-care, toileting, transferring. The resident needed supervision with bathing. Interviewed on at 1:20 PM the Administrator acknowledged that the concern problems and stated, "Okay." Class II	A 025		
A 027 SS=I	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , , and remind residents about scheduled , , for medical, dental, nursing, or mental health	A 027		

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A 027	Continued From page 14 services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to assist with the arrangement of health care services for six out of fifty nine sampled residents (29, 23, 22, 17, 37, 30) Resident 29's primary care physician was not notified after he became unresponsive and had difficulty breathing, Resident 23 was in an altered state of mind without intervention for five days before she was sent to the hospital and Resident 17, Resident 22, Resident 37, and Resident 30 had unreported with injuries. Findings include: 1) A review of the facility's census showed that on Resident 29 was in the hospital. A review of Resident 29's nurses' notes dated showed that he was sent to the hospital due to a possible and . Further review of Resident 29's nurse's notes dated showed that staff AI called the nurse on duty because the Resident became unresponsive and his , were closed, his was wide open, had difficulty breathing and he was unable to speak or communicate with	A 027		

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A 027	Continued From page 15 the staff. Further review showed that the nurse found the Resident incoherent, but he was able to speak after about a minute, with a reading of . Further review of the nurses' notes revealed that Staff B and the Resident's son were notified, and the Resident's son refused to send the Resident to the hospital. Further review showed that the Resident's was checked again at saturation at 98% and he was alert, oriented and aware. Further review of the record showed no documentation that the Resident's episode was reported to his health care provider or the facility's actions to coordinate medical care and/or further evaluation of the Resident. A review of Resident 29's health assessment dated showed medical history and diagnoses of type II, ITP (purpura), multiple PEs ( ), ( ) No physical or sensory limitations. status was AAOx3 (Alert, awake and oriented to person, place, and time), not an elopement risk. precautions were indicated. ADL (Activities of daily living) showed assistance was needed with ambulation, bathing, self-care, toileting and transferring. Needed assistance with self-administration of medications. According to the Mayo Clinic , (PE) is a clot that blocks and stops flow to an in the . Because one or more clots blocks flow to the can be life threatening. Common symptoms include and fainting. A	A 027		

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A 027	Continued From page 16 , , can be life threatening. Urgent medical attention must be sought if experiencing unexplained , , or fainting. Interviewed on at approximately 3:00 pm Staff L stated that on 11/28/2023 at around 8:00 pm she was called to the Resident's room because he wasn't responsive. Staff L stated that she waited for Staff B and the doctor was called but did not answer. Staff stated that the Resident's , was checked again, it was normal, and her supervisor, Staff B, made the determination not to refer the Resident for further evaluation. Staff L stated that the resident was monitored during the rest of her shift without incident. A review of the facility's resident pendant call log showed that there were 6 calls to the staff from Resident 29's room on and on . Further review showed that one call on at 9:10 pm had an elapsed response time of over 20 minutes (Photographic evidence obtained) Further review of Resident 29's record showed there was no documentation of the facility's actions to coordinate medical care for the Resident after the episode on . There was no documentation that the Resident was evaluated by his health care provider. 2) A review of Resident 23's hospital record showed that she was sent to the hospital on after 5 days of altered mental state with increased agitation, aggressiveness, and poor intake. Further review showed the Resident was	A 027		

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A 027	Continued From page 17 admitted for rehydration with fluids and evaluation of changes in mental status. The Resident was evaluated by , and medications were adjusted. The case was discussed with the Resident's daughter, and they agreed on hospice care. The Resident was discharged to the ALF with hospice care on with discharge diagnoses of progression , acute , injury on , (Resolving) and . A review of Resident 23's record showed no documentation that the health care provider was notified that the Resident had for five days before she was sent to the hospital. A review of Resident 23's health assessment dated showed to sulfa . Diagnoses: , , , advanced precautions. No elopement risk. Supervision of all activities of daily living, except independent on eating. Assistance with medications. Further review of Resident 23's nurse's notes dated showed that Resident 23 , on hospice care. Interviewed on at approximately 2:00 pm when asked about documentation that the health care provider was notified when Resident 23 was in an altered state of mind the Administrator acknowledged and did not respond. 3) Observation on at approximately	A 027		

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A 027	Continued From page 18 12:15 pm showed that a PDA (Private duty aide) was assisting Resident 17 walking to a chair in his room. Further observation showed that Resident 17 had difficulty walking and was limping. Interviewed on . . . . . at approximately 12:13 PM Resident 17's wife stated, "He two or three times." Interviewed on . . . . . at approximately 12:25 PM the PDA stated, ""His ˬ hurts because he had a . . He two or three times." "He tried to get up from the chair. He did not have . . . . . Rescue was not called; he did not go to the hospital. I came in two or three days after. I have the pictures on my phone, I took it for my own protection after I saw his injuries." A review of photographic evidence provided by the Resident's daughter showed . . . . . on the ˬ and the arm of the Resident. (Photographic evidence obtained) Interviewed on . . . . . at approximately 12:35 pm Resident 17's daughter stated, "He twice in one month, I was there the second time he . It was on ; I went downstairs, and he . . He did not go to the hospital, there was nothing broken. 'Staff B' came in right away. He assessed him and they took care of his and the , ˬ , ˬ here" Resident 17's daughter stated that Staff B evaluated the Resident, and it was determined that there was no need to call rescue or send him to the hospital. A review of Resident 17's record showed no documentation of any recent . There was no documentation of the facility's actions to	A 027		

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A 027	Continued From page 19 coordinate medical care after the . . There was no documentation that the was reported to the Resident's health care provider. Further review of Resident 17's record showed no documentation that Resident 17 was evaluated by his health care provider after his . . . A review of Resident 17's nurses' notes dated showed, "Resident found on the floor on Saturday morning at around 8:00 am by his PDA. The Resident did not sustain any injuries and did not complain of any , . on assessment and during follow-up. He stated that he was going to the bathroom and could not reach his walker and placed himself on the floor." Further review of the Residents record showed no documentation that the Resident's . was reported to his health care provider. A review of Resident 17's health assessment of . . . . . showed medical history and diagnoses of normal pressure , , , physical limitations of gait and balance, the use of a walker and wheelchair for long distances, mild . . , , no nursing/treatment, or , , requirements were indicated. precautions. The ADL (Activities of Daily Living) assessment showed he was independent for ambulation, ... , eating, self-care, toileting, transferring and required assistance with bathing. Able to administer his own medications, his family managed the pill box. Interviewed on at approximately 1:35 pm when asked why Resident 17 was limping and had , in his , Staff B stated that he had . conditions since he was admitted to the facility and that he suffered from in the	A 027		

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A 027	Continued From page 20 , . Staff B denied that Resident 17 had any and stated that the , and difficulty walking was the natural progression of his condition. Staff B stated that the Resident was not receiving any rehabilitation due to insurance restrictions and the family had arranged that. 4) Observation on at 10:45 am showed that Resident 37's right . , was slightly , of darker color and . Interviewed on at approximately 10:47 am when asked about Resident 37's the Resident's PDA (Private duty aide) stated "He's had that cut over his , since he about 2 months ago. He is 93, he 3 times, the last time was about 2 months ago." A review of Resident 37's record showed no documentation that the Resident had a on . Further review showed no documentation that the Resident's was reported to his health care provider. A review of Resident 37's health assessment dated showed no known , medical history and diagnoses of 's , , , , angioplasty, family history of , physical limitations of unstable gait, and decline due to conditions, nursing requirements of , , , and high risk of precautions. Further review of the Resident's activities of daily living assessment showed he needed supervision with eating and assistance with ambulation, bathing, , self-care, toileting and transferring. The Resident needed assistance with self-administration of medication.	A 027		

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A 027	Continued From page 21 Interviewed on at 3:45 pm when asked why there was no documentation regarding Resident 37's on and that it had been reported to his health care provider Staff B stated that there was an incident report but that it was not part of the Resident's record. Staff B stated that 911 was called and it was determined that Resident 37 did not need to go to the hospital and that the Resident's son had agreed to that. Staff B also stated that he had recommended to the Resident's son that the Resident should be placed in hospice care. A review of the facility's record dated showed that Resident 37 was found on the floor, and he stated that he did not remember how he . Further review showed, "Resident refused 911, he doesn't need to go to the hospital, 911 said he was OK." 5) A review of Resident 22's nurses' notes dated showed that the Resident in her room and had an open on her forehead that required suturing at the hospital. Further review showed that Resident 22 was taken to the hospital by family, and returned with on her forehead. A review of facility records for Resident 22 dated at 8:30 pm showed, "Resident in her room under the care of the private aid when she was changing her clothes, she lost her balance and hit her with the dresser; open noted on forehead cm, needs to be sutured in ER. The Resident was transferred by family to hospital for evaluation. Cleaned and applied gauze and tape." Follow up required	A 027		

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A 027	Continued From page 22 by the hospital for [illegible] and probable concussion. A review of Resident 22's health assessment dated [illegible] showed diagnoses of [illegible] and [illegible]'s [illegible] status showed alert and disoriented. Physical limitations, N/A, special precautions, N/A. The ADL (Activities of daily living) evaluation showed she needed assistance with ambulation, bathing, [illegible], eating, self-care, toileting and transferring. Further review showed she required 24-hour [illegible] care. A review of the hospital record dated 11/22/2023 showed that the resident was brought to the emergency room at approximately 9:52 pm by a relative who stated that he had last seen the resident a 6:00 pm, at which time she was fine and uninjured. Further review showed that the resident suffered a blunt [illegible] to her forehead and [illegible], resulting in a 3 cm [illegible]. The [illegible] was repaired and the resident needed to follow up with her primary care provider within two days.. Further review of Resident 22's record showed no documentation that the Resident's [illegible] was reported to her primary care provider. There was no documentation that the Resident received follow up care. 6) A review of Resident 30's progress notes dated [illegible] showed, "Resident reported he inside apartment in bedroom area he was observed with [illegible] at left [illegible], left [illegible], and hematoma at left [illegible]. Daughter and 'Staff B' notified."	A 027		

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A 027	Continued From page 23 Further review of Resident 30's nurses' notes dated showed, "Resident was placed on critical care by hospice who advised to stop all until the team follows up with evaluations." According to the Cleveland Clinic, " , such as a car accident or major , can cause a hematoma. A hematoma is a larger collection of outside of that is typically raised and causes , to the touch." Further review of Resident 30's record showed no documentation that the Resident's was reported to his primary care physician. Further review showed no documentation of the facility's actions to coordinate follow-up care with the primary care physician for the Resident after the . A review of Resident 30's health assessment dated showed diagnoses of , high , Tinnitus, tremors. Physical limitations showed uses walker for long distances. status showed alert and oriented to time person and place. The nursing/treatment/ , , service requirements showed "N/A". The resident had precautions. Activities of daily living showed independent in bathing, , eating, self-care, toileting, transferring, and supervision with ambulation and transferring. Further review of Resident 30's progress notes dated showed, "Resident , , on hospice, family and doctor informed	A 027		

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A 027	Continued From page 24 funerary home call by hospice nurse time of : 9:35 PM ." Interviewed on at approximately 2:00 pm when asked about documentation that Resident 30's received medical care for his injuries resulting from his on the Administrator acknowledged it and did not respond. Class II	A 027		
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.	A 052		

Agency for Health Care Administration

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A 052	Continued From page 25 (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. (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	A 052		

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A 052	Continued From page 26 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 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	A 052		

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A 052	Continued From page 27 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 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 and interview the facility	A 052		

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A 052	Continued From page 28 failed to ensure the staff followed the procedures outlined by the State when assisting one out of fifty-nine residents with self-administration of medications (Resident #24). Findings include: Observation on at approximately 8:45 AM showed that Staff AH (caregiver) came out of where Resident 24 lived. Further observation showed that Resident 24 was sitting at the table with a cup of coffee and medication outside the containers laid out on a napkin in front of the Resident. Observation revealed that Staff AHreentered the resident room. Interviewed on at approximately 8:47 AM Staff AH stated that Resident 24 liked to count her pills and that she had taken the spray on her own. She stated that she counted out the pills, gave them to the resident, locked up the containers, then went into the room to assist Resident #24 with taking the medications. Observation on at approximately 8:48 AM revealed that Staff AH picked up each pill with her bare and handed each one to Resident #24. Staff AH did not identify the pills to the resident. When asked if she had observed the resident using the spray, Staff AH stated that she had not. A review of the resident record found no waiver indicating that Resident #24 did not want the medications to be identified. Observation on at approximately 8:48 AM showed that Staff AH applied , , to Resident 24's , and was not wearing gloves. Further observation revealed that Staff AH	A 052		

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A 052	Continued From page 29 returned to the medication cart, reviewed the Medication Observation Record and signed off several medications as given. Further observation revealed that several medications had already been signed off. Observation revealed that Staff AH then sanitized her and donned unused gloves. Interviewed on [redacted] at approximately 2:00 pm when it was explained that Staff AH was observed leaving medications unsecured and unattended in the room, did not observe the Resident when she was applying the [redacted] spray, did not wear gloves when handling the medication pills and applying [redacted] to the Resident, the Administrator acknowledged it and made no comments. 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:	A 054		

Agency for Health Care Administration

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A 054	Continued From page 30 1. The name of the resident and any known 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 , 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 observations, record review and interview, the facility failed to immediately update the Medication Observation Record (MOR) each time the medication was offered for one (#34) out of 88 residents. Findings: Observation on at 8:30 AM revealed Staff AD (Medical Technician) initial the MOR before offering and observing Resident #34 use the Spray. Interviewed on at 8:30 AM Resident #34 she had taken her spray on her own. A review of Resident #34's MOR showed some medications were documented as given prior to the medications being given. Interviewed on at 1:30 PM the Administrator acknowledged the problems and stated, "Okay."	A 054		

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A 054	Continued From page 31 Class III	A 054		
A 056 SS=G	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.	A 056		

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A 056	Continued From page 32 (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name,	A 056		

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A 056	Continued From page 33 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow medication discharged instructions for one (#23) out of 88 sampled residents. The facility continued to give Resident #23 a medication that was discontinued, and withheld a prescribed medication for one of 88 sampled residents. Finding: A review of Resident #23's discharge diagnosis dated ..... showed: "... female patient with a history of advanced , recurrent ..., who presented to hospital after 5 days of ..... (AMS) with increased agitation, aggressiveness, and poor oral intake. Patient admitted for rehydration with (intra-) fluids monitoring of failure after failure and evaluation of changes in mental status. Work up for organic etiologies negative thus far. Psych consulted for assistance with agitation. Patient was evaluated by ..., and her medications adjusted. Patient was able to sleep all night yesterday, she is tolerating food and liquids PO (by ...)."	A 056		

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A 056	Continued From page 34 A review of the discharge medications to stop taking as of showed: " 25 MG, 25 MG, 10 MG, 300 MG, 30 MG, 325 MG, 30 MG, / ER (ER 28/10 MG." The following list was the list to continue taking: " / ER (ER 28/10 MG)." The following list was the list to start taking the new medications: , 50 MG and to start taking the new medications: " , 7.5 MG, , 250 MG/5 ML Solution, 3 MG as needed." The following medication have been changed: " , 5 MG to 10 MG." A review of the medication observation record (MOR) for showed the medication , 10 MG, was given for 17 days from through . In addition to , 10 MG being given, the medications that the primary care physician ordered to stop taking as of , 30 MG, was given on - (3 days), 10 MG on - (2 days), and on -. According to the National Library of Medicine, " , tablets and extended-release (long-acting) tablets are used to treat the symptoms of , (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). , tablets and extended-release tablets are also used alone or with other medications to treat episodes of (frenzied, abnormally excited or irritated) or , in patients with , (, ; a that	A 056		

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A 056	Continued From page 35 causes episodes of , , episodes of , and other abnormal moods). In addition, , tablets and extended-release tablets are used with other medications to prevent episodes of or , in patients with , , extended-release tablets are also used along with other medications to treat , , tablets may be used as part of a treatment program to treat , and , in children and teenagers. , is in a class of medications called , , . It works by changing the activity of certain natural substances in the ." According to the National Library of Medicine, , is "used alone or in combination with other medications to treat high , in adults and children , and older. It is used in combination with other medications to treat , is also used to improve survival after a , is in a class of medications called angiotensin-converting , ( ) inhibitors." According to the National Library of Medicine, " is used to treat , in adults and generalized , (GAD; excessive worry and tension that disrupts daily life and lasts for 6 months or longer) in adults and children , and older. is also used to treat , and tingling caused by , (damage to that can develop in people who have) in adults and , (a long-lasting condition that may cause , stiffness and tenderness, tiredness, and difficulty falling asleep or staying asleep) in adults and children , and older. It is also used to treat ongoing bone or , such as lower , or	A 056		

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A 056	Continued From page 36 (, , or stiffness that may worsen over time) in adults. is in a class of medications called selective and , , reuptake inhibitors (SNRIs). It works by increasing the amounts of and , , , natural substances in the that help maintain mental balance and stop the movement of , signals in the ." According to the National Library of Medicine, is used along with diet, alone or in combination with another -lowering medications (HMG-CoA reductase inhibitors [statins]) to reduce the amount of low-density lipoprotein ( ) ('bad ') in the in adults and children , or older who have familial heterozygous , (an inherited condition in which cannot be removed from the body normally). According to the National Library of Medicine, "is a found in many over-the-counter supplements. Iron overdose occurs when someone takes more than the normal or recommended amount of this .". A review for the MOR for showed , 10 MG was no longer listed and the new medication, , NA 250 MG added by the PCP documented as needed rather than bedtime. Interviewed on at 12:00 PM the daughter of Resident #23 stated that her mother was not given the medications the doctor changed while she was in the hospital from - . The daughter stated further that after her mother was seen by her Primary Care Physician (PCP) and that the PCP took one look at her mother and stated that she	A 056		

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A 056	Continued From page 37 was not taking her medication. The daughter stated, "The [facility] did not follow the order. He took one look at her and said they never changed the medications. The [director of resident care] said he was not going to change the medication until he spoke to me. I told them we reviewed the medications. Everything that he read off was before the medication was changed." A review of Resident #23's health assessment dated [redacted] showed diagnoses of [redacted] (AMS), [redacted] ([redacted]), [redacted] and Advance [redacted]. The resident needed [redacted] precautions. The resident's activities of daily living showed the resident needed supervision with ambulation, [redacted], grooming bathing, toileting, transferring, and was independent with eating. The resident needed assistance with self-administration of medication. Interviewed on [redacted] at 11:56 AM Regarding following the medication adjustment order for Resident #23 from her PCP, The Director of Resident Care stated, "I am sure the medication was given. I know because of her daughter." Interviewed on [redacted] at 12:42 PM the daughter of Resident #23 stated, "With the medications...the last time it was worse. When I came [redacted] from out of town and I took my mother [redacted] to the doctor, the doctor stated, "I can guarantee you that they [facility] never changed her medication." Interviewed on [redacted] at 1:30 PM the Administrator acknowledged the problems and stated, "Okay."	A 056		

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A 056	Continued From page 38 Class II	A 056		
A 079 SS=H	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are	A 079		

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A 079	Continued From page 39 absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the	A 079		

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A 079	Continued From page 40 facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety	A 079		

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A 079	Continued From page 41 requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure sufficient staff were readily available to meet the scheduled and unscheduled needs for 88 out of 88 sampled residents, including 17 residents (1, 11, 20, 21, 22, 25, 26, 27, 28, 31, 33, 53, 54, 55, 56, 57, 58) on the memory care floor (3rd), where eight (1, 11, 26, 27, 28, 31, 33, 53) out of the 17 residents were under hospice care, and 13 residents (5, 8, 24, 29, 32, 38, 39, 40, 41, 42, 43, 44, 45) needed	A 079		

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A 079	Continued From page 42 a higher level of care on the 2nd, 5th, 6th, 7th, 8th, and 10th floors. The facility had nine employees including a supervisor on duty overnight, seven were found asleep. The facility also failed to respond to more than 103 calls for the month of , 66 calls for the month of , and 11 calls from - for more than 20 minutes. Findings: 1) Observation on at 1:05 AM Staff U (Caregiver), Staff V (Caregiver), and Staff W (Medical Technician) asleep together in the common area. Staff U had two chairs in opposite directions and outstretched and Staff V. Staff W was slumped over with phone in with phone in . A review of the census showed 88 residents in house. A review of the list of residents under hospice care and who needed assistance with activities of daily living showed 17 (5, 8, 24, 29, 32, 38, 39, 40, 41, 42, 43, 44, 45) residents under hospice care. A review of the list of residents who need frequent changes of adult briefs or other services more frequently than every two hours showed 13 (5, 8, 24, 29, 32, 38, 39, 40, 41, 42, 43, 44, 45) residents. Interviewed on at 1:05 AM Staff U stated that she was assigned to floors 6th, 8th, and 9th but did not answer when asked if they were sleeping. Interviewed on at 1:05 AM Staff V stated she was assigned to floors 6th, 7th, and 10th but did not answer when asked if they were	A 079		

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A 079	Continued From page 43 sleeping. Interviewed on . . . . . at 1:05 AM Staff W that she was assigned to floors 6th, 7th, and 10th but did not answer when asked if they were sleeping. Observation on at 1:20 AM found four employees, Staff X (Caregiver), Staff Y (Caregiver), Staff Z (Caregiver), and Staff AA (Caregiver) in the lobby area on the memory care floor with lights out and under covers asleep on the sofas. This was also observed by the Staff AE (Shift Leader). Interviewed on at 1:20 AM Staff AE stated that they were taking a break. Interviewed on . . . . . at 1:30 AM Staff X stated, "We do the rounds every 2 hours, but there are certain residents that we check every hour." When the staff was asked how they know when to see the residents if they were sleeping, Staff X stated, "Because I have the alarm on my phone." When asked to show the phone, observation revealed that no alarm was set. Observation on at 1:31 AM revealed Staff Y had her phone set for 2:00 am. Interviewed on . . . . . at 4:20 PM when asked about his whereabouts on at 1:00 AM, Staff AE stated that he was in the wellness center. When Staff AE was informed that Staff AH (Caregiver) was on the 2nd floor, Staff AE stated that he was in the break room and that he used the service elevator to come up to the 2nd floor when he was called. When asked about the employees sleeping, Staff AE stated, "From my knowledge, staff were allowed to	A 079		

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A 079	Continued From page 44	A 079		

sleep." When asked what residents needed more care, Staff AE stated, "I don't know who would need a high level of care. I do know that most of the residents on the third floor need a high level of care."

Interviewed on [redacted] at 4:15 PM regarding the employees sleeping on the 10th and 3rd floors, the Director of Nursing Care (DON) stated that the employees received a verbal warning. The DON stated, "I am going to talk to Supervisor [AE]. The staff (overnight) have one 30-minute break and two 15-minute breaks." When asked about residents needing more care, the DON stated, "More consistent in activities of daily living (ADLS), high risk for [redacted]. Almost one on one. The third floor already needs a high level of care because they have [redacted]."

A review of Resident #22's health assessment dated [redacted], showed diagnoses of [redacted].
The [redacted] status showed alert and disoriented. Resident #22 activities of daily living showed she needed assistance in ambulation, bathing, grooming [redacted], eating toileting and transferring. The resident required 24- hour nursing or [redacted] care.

A review of Resident #29's pendent calls from [redacted] through [redacted], who was transported to the hospital for [redacted]-like symptoms on [redacted], showed up to six (six) calls including one call that lasted more than 20 minutes:

[redacted]:10 PM 20:53 Minutes
[redacted]:20 AM 3:44 Minutes
[redacted]:21 AM 2:03 Minutes
[redacted]:22 AM 4:14 Minutes

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A 079	Continued From page 45 :10 AM 4:00 Minutes :49 AM 11:03 Minutes Reviewed nurse's notes dated for Resident #29 showed: "Resident sent to hospital due to possible and ." Reviewed Resident #29's health assessment dated showed diagnoses of II, history of purpura (ITP), The status showed awake, alert and oriented times three and forgetful at times. The resident had a precaution. The resident's activities of daily living showed assistance needed with ambulation, bathing, self-care, toileting, transferring and supervision needed with eating. 2) A review of the call pendant logs from - showed 13 calls went unanswered for more than 20 minutes and - , six calls went unanswered beyond 20 minutes. A review of the call pendant logs from /203- showed 66 calls went unanswered for more than 20 minutes. A review of the call pendant logs from - showed 103 calls went unanswered for more than 20 minutes. A review of the emergency call system policy states: "The emergency call button alerts will be	A 079		

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A 079	Continued From page 46 displayed on the computer in the wellness center on the 2nd floor. All wellness staff on shift will carry a phone that alerts staff when an emergency call bell goes off for a resident. Emergency call buttons for residents should be answered immediately and no later than 20 minutes. Any call answered after the 20-minute time frame must be covered by another staff member. Call answered after 20 minutes must be explained to Director of Resident Care and/or Administrator." Interviewed on [redacted] at 1:30 PM regarding the unscheduled and scheduled needs of residents, the Administrator stated, "I have staff. Okay." Below showed some of the residents under hospice care, including residents needing a higher level of care: Reviewed Resident #22's Health assessment dated [redacted] showed diagnoses of [redacted]. The resident needed assistance with ambulation, bathing, [redacted], grooming, eating, toileting, and transferring. The resident Required 24-hour nursing or [redacted] care. Reviewed Resident #1's health assessment dated [redacted] showed diagnoses of major [redacted], absolute [redacted]. The resident's activities of daily living showed assistance needed with ambulation, bathing, [redacted], eating, self-care, toileting and transferring. The resident was under hospice care. Reviewed Resident #21's health assessment	A 079		

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A 079	Continued From page 47 dated showed diagnoses of ( ), The physical or sensory limitations showed . The or behavioral status showed . The nursing/treatment/ service requirements stated memory care. The resident had special precautions. The resident's activities of daily living showed independent in ambulation, bathing, , eating, self-care, toileting, and transferring. Reviewed Resident #24's health assessment dated showed diagnoses of , pre- , ( ), . The physical or sensory limitations showed ambulates with walker. The or behavioral status showed alert appropriate, forgetful. The resident had no precautions. The activities of daily living showed independent with ambulation, bathing, , eating, self-care, toileting, and transferring. Reviewed Resident #26's health assessment dated showed diagnoses of 's , , AMS ( ), . The Nursing treatment and requirements showed hospice and memory care. The resident's activities of daily living showed total care was needed with with ambulation, bathing, , self-care, toileting and transferring and assistance needed with eating. Reviewed Resident #27's health assessment dated showed diagnoses of , ( ), , GAIT abnormalities. The physical limitations showed uses walker. Resident's nursing/treatment/ services requirements showed hospice care. Resident's	A 079		

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A 079	Continued From page 48 activities of daily living showed total care with ambulation, bathing, ب, self-care, toileting and transferring but independent with eating. Reviewed Resident #28's health assessment dated showed a diagnoses (, body) , agitation, sleep . The physical or sensory limitations showed gait . The or behavioral status showed , agitation. The nursing/treatment/ , requirements showed memory care, hospice care. The resident had a precaution. The activities of daily living showed total care in ambulation, bathing, ب, self-care, toileting, transferring and assistance needed with eating. Reviewed Resident #31's health assessment dated showed resident needed assistance with ambulation, bathing, ب, eating, self-car, toileting and transferring. Reviewed Resident #32's health assessment dated showed Pubic , degenerative , , , , . The status showed calm & , and history of , and . Nursing/treatment, , service requirements showed RN (registered nurse) for evaluation. The resident needed assistance with all activities of daily living. Class II	A 079		
A 162 SS=E	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:	A 162		

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A 162	Continued From page 49 (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the 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 practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in	A 162		

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A 162	Continued From page 50 writing that [illegible] 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 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	A 162		

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A 162	Continued From page 51 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 , 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 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 observation, review of records and interview the facility failed to maintain an accurate and up-to-date health assessment for two out of fifty-nine sampled residents (17, 32) Findings included: Observation on at approximately	A 162		

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A 162	Continued From page 52 12:15 pm showed that a PDA (Private duty aide) was assisting Resident 17 walking to a chair in his room. Further observation showed that Resident 17 had difficulty walking and was limping. A review of Resident 17's health assessment of showed a medical history and diagnoses of normal pressure , physical limitations of gait and balance, the use of a walker and wheelchair for long distances, mild , , no nursing/treatment, or requirements were indicated. precautions. Further review of Resident 17's ADL (Activities of Daily Living) assessment showed he was independent for ambulation, , eating, self-care, toileting, transferring and required assistance with bathing. Able to administer his own medications, his family managed the pill box. Interviewed on at approximately 1:35 pm when asked why Resident 17 was limping and had , in his Staff B (Director of Resident Care) stated that he had conditions since he was admitted to the facility and that he suffered from in the , Staff B denied that Resident 17 had any , that his , and difficulty walking was the natural progression of his condition. Staff B stated that the Resident was not receiving any rehabilitation due to insurance restrictions and the family had arranged that. Observation on at approximately 9:30 AM showed that Resident 32 was sitting on a recliner in . Further observation showed that the Resident's breakfast had been served on the dining table. Interviewed on at approximately 9:32	A 162		

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A 162	Continued From page 53 AM Resident 32 stated that he needed help transferring from the chair and was waiting for the staff to help him move to the table to eat his breakfast. Interviewed on at approximately 9:40 AM Staff H stated that Resident 32 needed help transferring. Staff H stated, "We need two people to help him, he is heavy." A review of Resident 32's health assessment dated showed pubic , degenerative , status showed calm & and history of and . Nursing/treatment, service requirements showed RN for evaluation. daily/HHA to help with ADLS. The resident had a precaution. The resident's activities of daily living showed resident needed supervision in ambulation, bathing, , self-care, toileting, and transferring, but resident was independent in eating. Resident needs assistance with self-administration of medication. Further review of Resident 32's health assessment record showed that he needed supervision with ambulating. Class III	A 162		
A 165 SS=F	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality	A 165		

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A 165	Continued From page 54 assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or , damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.	A 165		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 165	Continued From page 55 (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary	A 165		

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A 165	Continued From page 56 proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on observation, review of records and interview the facility failed to file an adverse incident report for four out of fifty-nine sampled residents that had with injuries (17, 22, 30, 37). The facility also failed to report one out of fifty-nine sampled residents that was transferred to the hospital after five days of (23). Findings include: 1) Interviewed on at approximately 12:13 pm Resident 17's wife stated that Resident 17 had two or three . She stated, "His hurts because he , He two or three times." Observation on at approximately 12:15 pm showed that a PDA (Private duty aide) was assisting Resident 17 walking to a chair in his room. Further observation showed that Resident 17 had difficulty walking and was limping. Interviewed on at approximately 12:25 pm Resident 17's Private Duty Aide (PDA) stated, "He had a when he tried to get up from the chair." Interviewed on at approximately 12:35 pm Resident 17's daughter stated, "He twice in one month, I was there the second time	A 165		

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A 165	Continued From page 57 he . It was on . He did not go to the hospital. [Staff B] came in right away and he assessed him." Resident 17's daughter also stated that Staff B evaluated the Resident and that it was determined that there was no need to call rescue or send him to the hospital. She stated, "They arranged for the care and the , to be done here." A review of photographs of Resident #17 and arm taken after the showed (Photographic evidence obtained). Interviewed on at approximately 1:35 pm when asked why Resident 17 was limping and had , in his , Staff B (Director of Resident Care) stated that Resident 17 had conditions since he was admitted to the facility and that he suffered from in the , . Staff B denied that Resident 17 had any , and stated that his , and difficulty walking was the natural progression of his condition. Staff B stated that the Resident was not receiving any rehabilitation due to insurance restrictions and the family had arranged , . A review of Resident 17's health assessment of showed medical history and diagnoses of normal pressure , , , physical limitations of gait and balance, the use of a walker and wheelchair for long distances, mild , , no nursing/treatment, or , requirements were indicated. precautions. The ADL (Activities of Daily Living) assessment showed he was independent for ambulation, , eating, self-care, toileting, transferring and required assistance with bathing. Able to administer his own medications, his family managed the pill box.	A 165		

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A 165	Continued From page 58 A review of Adverse Incident Reports from the facility showed that non had been submitted regarding Resident 17's . 2) A review of Resident 22's nurses' notes dated showed that the Resident in her room while under the care of a private aide who was assisting the resident to change her clothes, and had an open on her forehead that required suturing at the hospital. There was no documentation that staff was assisting the resident with . Further review showed that Resident 22 was taken to the hospital by family, and returned to the facility from the hospital with on her forehead. A review of Resident 22's health assessment dated showed diagnoses of and 's status showed alert and disoriented. Physical limitations, N/A, special precautions, N/A. The ADL (Activities of daily living) evaluation showed she needed assistance with ambulation, bathing, , eating, self-care, toileting and transferring. Further review showed she required 24-hour care. A review of Adverse Incident Reports from the facility showed that non had been submitted regarding Resident 22's . 3) A review of Resident 30's progress notes dated showed, "Resident reported he inside apartment in bedroom area he was observed with at left , left ,	A 165		

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A 165	Continued From page 59 and hematoma at left . , . . Daughter and 'Staff B' notified." According to the Cleveland Clinic, " , such as a car accident or major . , can cause a hematoma. A hematoma is a larger collection of . . . . outside of . . . . . that is typically raised and causes , to the touch." A review of Resident 37's health assessment dated . . . . . showed no known . . . . , medical history and diagnoses of 's . . . . . , angioplasty, family history of , physical limitations of unstable gait, ... and decline due to conditions, nursing requirements of . , ... , and high risk of precautions. Further review of the Resident's activities of daily living assessment showed he needed supervision with eating and assistance with ambulation, bathing, ... , self-care, toileting and transferring. Further review of Resident 30's progress notes dated . . . . . showed, "Resident , ... , on hospice, family and doctor informed funerary home call by hospice nurse time of : 9:35 PM ." A review of Adverse Incident Reports showed that the facility had not submitted an incident report regarding Resident 30's . 4) Observation on at 10:45 am showed that Resident 37's right . , . . was slightly , of darker color and . Interviewed on at approximately	A 165		

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A 165	Continued From page 60 10:47 am when asked about Resident 37's ... the Resident's PDA (Private duty aide) stated "He's had that cut over his ... since he ... about 2 months ago. He is 93, he ... 3 times, the last time was about 2 months ago." A review of Resident 37's record showed no documentation that the Resident had a ... on ... Further review showed no documentation that the Resident's ... was reported to his health care provider. Interviewed on ... at 3:45 pm when asked about documentation about Resident 37's ... on ... and that it had been reported to his health care provider Staff B stated that it had been documented in an incident report but that it was not part of the Resident's record. Staff B stated that 911 was called and it was determined that Resident 37 did not need to go to the hospital and that the Resident's son had agreed. Staff B also stated that he had recommended to the son that the Resident should be placed in hospice care. A review of the facility's incident report dated ... showed that Resident 37 was found on the floor, and he stated that he did not remember how he ... Further review showed, "Resident refused 911, he doesn't need to go to the hospital, 911 said he was OK." A review of Adverse Incident Reports from the facility showed that none had been submitted regarding Resident 37's ... 5) A review of Resident 23's hospital record showed that she was sent to the hospital on	A 165		

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A 165	Continued From page 61 after 5 days of altered mental state with increased agitation, aggressiveness, and poor intake. Further review showed the Resident was admitted for rehydration with fluids and evaluation of changes in mental status. The Resident was evaluated by , and medications were adjusted. The case was discussed with the Resident's daughter, and they agreed on hospice care. The Resident was discharged to the Assisted Living Facility (ALF) with hospice care on with discharge diagnoses of progression 's , acute , injury on , (Resolving) and . A review of Resident 23's health assessment dated showed to sulfa . Diagnoses: , , , advanced . precautions. The resident needed supervision with all activities of daily living, except independent on eating. Further review of Resident 23's nurse's notes dated showed that Resident 23 , under hospice care. A review of Adverse Incident Reports showed that the facility had not submitted one regarding Resident 23's hospitalization to which she was not able to give consent.. Interviewed on at approximately 2:00 pm when informed that adverse incident reports were not filed after Residents 30, 22 and 30's had and after Resident 23 was hospitalized for altered state of mind the Administrator acknowledged it and did not respond.	A 165		

Agency for Health Care Administration

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A 165	Continued From page 62 Class III	A 165		