Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11966084	A. BUILDING: _____ B. WING _____	R 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TITUSVILLE TOWERS	405 INDIAN RIVER AVENUE TITUSVILLE, FL 32796

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit to a relicensure survey with Extended Congregate Care (ECC) was conducted at Titusville Towers on . The facility had an uncorrected deficiency at the time of the survey.	{A 000}		
{A 025} SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and 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	{A 025}		

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{A 025}	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interviews, the facility failed to administer medications as prescribed by a health care practitioner to 1 of 5 sampled residents who required assistance with medications and failed to notify a health care practitioner as prescribed when the same resident's was greater than 400 (#19). Findings: A review of resident #19's record revealed a facility admission date of . The resident's	{A 025}		

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{A 025}	Continued From page 2 medical history included type 2 and . The resident's health assessment form (1823) documented the resident required assistance with self-administration of medications. A review of the resident's Medication Observation Record (MOR) revealed an entry for injection per twice daily and to contact the provider if was over 400. On the resident's was documented as 448. Neither the MOR nor the resident's progress notes had documentation to indicate a provider was contacted. On at 2:54 pm, med tech F, who documented the , said that generally when a resident's was greater than 400, she called or texted nurse H or nurse I from the facility's mobile phone. Med tech F could not remember if she contacted either of the nurses when resident #19's was 448. When asked if she could review text messages from that date, med tech F replied that all text messages were cleared off the phone at the end of the day. On at 4:05 pm, nurse H said she looked on her phone and there was nothing on it to prove that med tech F informed her of the resident's result. On at 4:23 pm, nurse I said he looked on his phone and there was nothing on it to prove that med tech F informed him of the resident's result. A review of resident #19's MOR	{A 025}		

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{A 025}	Continued From page 3 revealed , 75 milligrams twice daily was signed as given on at 8 am by med tech G. However, a review of the control drug sheet revealed the 8 am dose was not signed as given. A review of the residents' progress notes revealed none addressed this discrepancy. On at 3:15 pm, med tech G reviewed the documentation then said "I had to just not give it to her. That was my mistake". Class III	{A 025}		