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
	AL11922279	A. BUILDING: _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS OF EASTBROOKE	201 SUNSET DRIVE CASSELBERRY, FL 32707

(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 056 SS=D	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. (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	A 056		

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A 056	Continued From page 1	A 056		

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,
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.,

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A 056	Continued From page 2 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 observations, record reviews and interviews, the facility allowed an unlicensed caregiver to write a verbal order from a health care practitioner for 1 of 14 sampled residents (#8). Findings: A review of resident #8's record revealed a facility admission date of . The resident's medical history included type 2, and . The resident required assistance with self-administration of medications. During an interview on at 10:25 am, resident #8 was seen scratching both of his upper inner thighs. Redness and bumps were seen on his skin. The resident said the itching had persisted for approximately one month. The resident said he informed facility staff. Caregiver A was walking by and said she put cream on the areas. Continued review of the resident's record revealed there was no facility documentation nor an order from a health care practitioner regarding the resident's skin irritation. During an interview on at 9:55 am, caregiver A said she applied cream on resident #8's thighs on .	A 056		

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A 056	Continued From page 3 During an interview on at 1:35 pm, caregiver A said she first saw the condition of resident #8's thighs on . The caregiver said she reported her findings to the Assistant Director of Nursing (ADON), who was not a nurse. Caregiver A said she did not document what she saw on the resident's thighs that prompted her to apply the cream. During an interview on at 2:14 pm, the ADON said caregiver A did tell her about the resident's skin irritation. The ADON then said she would obtain an order for cream. During an interview on at 2:25 pm, the ADON provided a written verbal order that she signed herself to apply twice daily to groins. The ADON then said she looked at the resident's skin today and saw only redness on the resident's thighs, , and . When asked if she had informed a nurse of her observations, she replied that she informed the DON, who was not working that week. When reminded of this, the ADON then said she informed the Licensed Practical Nurse (LPN) consultant, who was present during the survey. When questioned, the LPN consultant said the ADON did not tell her. When the ADON was asked why she said she told the LPN consultant when she had not, she replied "I didn't understand the question". When the ADON was asked why she took a verbal order from the health care practitioner when she's not a nurse, the RN consultant who was present spoke up and said both she and the LPN consultant were present when the ADON was on speaker phone with the health care practitioner. The LPN consultant confirmed she was present during the call. When the RN consultant was asked why she	A 056		

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A 056	Continued From page 4 did not write the order herself she replied that she was busy doing something else at the time then immediately said she was showing the ADON how to take the order. When the LPN consultant was asked why she did not write the order she replied that she did not know why. A review of the facility's ADON job description revealed the education requirements for the position was possession of a current State of Florida nursing license. A review of the ADON's personnel record revealed she held a certified nursing assistant (CNA) license and not a nursing license. Class III	A 056		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of . . . . . testing materials satisfies the annual	A 078		

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A 078	Continued From page 5 . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility . . . . . to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,	A 078		

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A 078	Continued From page 6 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation and experience by allowing unlicensed staff to apply an Ankle . . . . . (AFO) brace to 1 of 14 sampled residents (#19); and failed to ensure 1 of 8 sampled staff (registered nurse consultant) submitted a written statement from a health care provider documenting that the individual did not have any signs or symptoms of communicable . . . . . within 30 days after beginning employment and that the same staff's personnel record contained evidence of a negative . ( ) examination on an annual basis (registered nurse consultant). Findings: 1. A review of resident #19's record revealed the resident's medical history included . . related to , poor short-term memory, , , ... Lymphedema, Radiculopathy, . . . Insufficiency, ... , Adult . . . . . , poor balance and gait , . The resident needed assistance with bathing, ... , grooming and toileting. On at 10:07 am, resident #19 was seen sitting in a wheelchair. She had an AFO brace on her left lower . An attempt was made to	A 078		

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A 078	Continued From page 7 interview the resident about the brace, but her responses were unrelated to the questions. Continued review of the resident's record revealed there was no health care practitioner's order for the brace nor any documentation to indicate facility staff were applying it. On ... . at 3:15 pm, caregiver E said she applied resident #19's AFO brace that morning. When asked if the resident was able to put the brace on herself the caregiver replied "I don't think so because sometimes she can't even get out bed and I have to help her. I don't think she can bend down to put it on herself". A review of caregiver E's personnel record revealed a CNA license and not a nursing license. On at 4:33 pm, the facility administrator said there was no order for the brace and said she did not know the resident had an AFO brace. 2. The registered nurse consultant's personnel record revealed a hire date of . There was no documented evidence of a negative ( ) exam with a statement free from communicable . . . . . from a healthcare provided as required within 30 days after beginning employment. On ... . at 4:15 PM, an interview with the Business Office Manager confirmed the findings. Class III	A 078		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff	A 161		

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A 161	Continued From page 8 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c),	A 161		

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A 161	Continued From page 9 F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ⌄ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to obtain a copy of the job description for 1 of 8 sampled staff (registered nurse consultant) for a facility that has 17 or more residents as required. Findings: The registered nurse consultant's personnel record revealed a hire date of . There was no documented evidence of a job description in the record. On at 4:15 PM, an interview with the Business Office Manager confirmed the finding. Class III	A 161		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows:	A 162		

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A 162	Continued From page 10 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 writing that [illegible] not be taken.	A 162		

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A 162	Continued From page 11 (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 recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , , 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 , , of a health care surrogate, health care proxy,	A 162		

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A 162	Continued From page 12 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 [redacted], 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 resident record review and interview, the facility failed to obtain a demographic [redacted] sheet and the legal Guardianship order for 1 of 14 sampled resident (#11) as required. Findings: Resident #11's record review revealed an admission date of [redacted]. The 1823 Health	A 162		

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A 162	Continued From page 13 Assessment dated [redacted] listed medical history of Severe [redacted], High [redacted], and [redacted]. He has limited communication. He is independent with ambulation, [redacted], bathing, eating, and transferring and supervision with grooming and toileting with activities of daily living (ADLs). He needs assistance with self-administration of medications. There was no demographic [redacted] sheet and no copy of the legal court appointed guardianship order in the record. On [redacted] at 2:55 PM, an interview with the Administrator confirmed the findings. Class III	A 162		
CZ816 SS=D	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's [redacted] to the Federal Bureau of Investigation for a national criminal history record check unless the person's [redacted] are enrolled in the Federal Bureau of Investigation's national retained print [redacted] notification program. If the [redacted] of	CZ816		

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CZ816	Continued From page 14 such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit [illegible] electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the [illegible] to the Federal Bureau of Investigation for a national criminal history record check. The [illegible] shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and	CZ816		

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CZ816	Continued From page 15 employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if . . . . . for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered	CZ816		

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CZ816	Continued From page 16 with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on the Background Screening (BGS) website, personnel record review and interview, the facility failed to have 1 of 8 sampled staff (registered nurse consultant) sign and date the Attestation of Compliance with Background Screening requirements, AHCA Form 3100-0008 as required. Findings: The registered nurse consultant's personnel record revealed hire date . . . . . There was no evidence that she signed the attestation of compliance for Background Screening (BGS). She was updated on the facility's BGS employee roster on . . . . . . A review of the Background Screening (BGS) website on at 4 PM revealed an eligible Level 2 BGS screening result dated . . . . . . On at 4:20 PM, an interview with the Business Office Manager confirmed the finding.	CZ816		

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CZ816	Continued From page 17 Class III	CZ816		
A 000	Initial Comments A re-licensure survey, Complaint Investigation #2023016773 and a generator monitoring was conducted at Gardens of Eastbrooke Assisted Living Facility & Memory Care on and . The facility had deficiencies at the time of the survey visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the	A 008		

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A 008	Continued From page 18 appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided	A 008		

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A 008	Continued From page 19 that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,	A 008		

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A 008	Continued From page 20 6. Whether the individual has signs or symptoms of , , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided.	A 008		

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A 008	Continued From page 21 (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish , , to be administered in the case of or , , . (f) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility failed to obtain all the information	A 008		

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A 008	Continued From page 22 required on an 1823 Health Assessment, AHCA Form completed by a healthcare provider for 2 of 14 sampled residents (#3 and #12). Findings: 1. Resident #3's record review revealed an admission date of . The 1823 Health Assessment dated listed diagnostic codes for medical conditions. She needs supervision with activities of daily living (ADLs) bathing, , and grooming and independent with eating, ambulation, toileting and transferring. She needs assistance with self-administration of medications. Resident #3 was recently admitted on to Hospice care. There was no other documented evidence that was provided to list the medical history instead of diagnostic codes. 2. Resident #12's record review revealed an admission date of . The 1823 Health Assessment, with no date listed medical history of with agitation, Major , , diffuse , and mastopathy of unspecified . She needs supervision with bathing, , and grooming. Independent with ambulation, eating, toileting and transferring. She needs assistance with self-administration of medications. There was no other documentation that was completed by a healthcare provider that could be used as the date for the 1823 Health Assessment. (Photographic Evidence Obtained)	A 008		

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A 008	Continued From page 23 On … at 2:20 PM, an interview with the Administrator confirmed the findings. Class III	A 008		
A 025 SS=G	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 24 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide adequate supervision by failing to assist 1 of 14 sampled residents out of a bathroom following care and the resident's was crushed, and partially when the door closed on it (#9), failed to give a medication as prescribed to 1 of 14 sampled residents (#8), failed to notify a health care practitioner when 1 of 14 sampled residents lost (#3), failed to document in the record of 1 of 14 sampled residents who had a delay in receiving , and failed to document in the record of 1 of 14 sampled residents who experienced a with injury (#17); and failed to have any facility documentation for 1	A 025		

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A 025	Continued From page 25 of 14 sampled residents (#11) as required. Findings: 1. A review of resident #9's record revealed a facility admission date of . The resident's medical history included severe , , and . An health assessment form (1823) documented the resident needed assistance with ambulation, bathing, , eating, grooming, toileting and transferring. The comments section documented " on assist with all care". On at 10:32 am, resident #9 was seen sitting in a wheelchair in the dayroom. An attempt was made to interview the resident, but the resident did not answer questions appropriately. During an interview on at 11:08 am, resident #9's family member said that a few months ago the resident almost lost a when a door shut on it. The family member said the had to be . The family member said the administrator said the family was not allowed to view the camera footage of the incident due to legal reasons. The family member said the administrator said she determined there was no foul play involved. The family member said that prior to the hospital visit for the the resident walked and now has to use a wheelchair. The family member then said the incident happened approximately weeks ago. The family member said they received a call on the night of the incident and was told by the caller that the resident was receiving a shower and when the door was closing the resident stuck her in the door.	A 025		

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A 025	Continued From page 26 An facility incident report documented that at approximately 10:05 pm resident #9 was receiving assistance in the bathroom from the ADON. Upon exiting the bathroom with the ADON the resident placed her on the door frame to support herself as the door was closing behind her. As the door closed, her right middle was pinched in the frame of the door causing a . The ADON called emergency services to transport the resident to the hospital. Pressure was maintained to the until emergency services arrived. The resident was taken to a hospital at approximately 10:20 pm. The resident's family was notified. A hospital history and physical documented the resident was brought in by ambulance with partial of right middle after crush injury from door. A hospital problem list documented . Status post accidental injury to the right third . Right third phalanx open with partial tuft . On exploration, debridement, Open Reduction Internal Fixation (ORIF) of right middle , repair of , and , local tissue rearrangement, fluoroscopy was performed. On at 8:30 pm the director of nursing (DON) documented that after toilet change, the resident's was caught in the door. The resident was sent to a hospital due to a . On at 4:01 pm the DON documented the resident's family member brought her to the facility. The resident was to follow up with a	A 025		

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A 025	Continued From page 27 doctor at the hospital on . . The resident had a ⌄ on her right . . On the family member took the resident to the follow up . , , ... On . . . . . a health care practitioner ordered ⌄ 625 milligrams (mg) 1 tablet by twice daily and . . , , . . . 100 mg 1 capsule by twice daily for 7 days and an , of right . . for . . ⌄. The results of the , were soft tissue ⌄ , . , of the 3rd ⌄ with fixation pin extending through the 3rd dip , . . but with cortical destructive changes of the phalanx; . . . . . , . . . is favored. On . . . . . a health care practitioner ordered . , 250 mg 1 tablet by twice daily for 10 days and an orthopedic , , ... On . . . . . a family member took the resident to the orthopedic , , . A hospital history and physical documented the resident was seen for a . . . injury. The right third phalanx open with partial . . . . tuft . , ... , possible A hospital discharge general information documented the reason for the visit was , , / . . ⌄ . postop. On the resident returned to the facility with her ⌄ . wrapped. On . . . . . at 3:36 pm the DON documented the resident's ⌄ was ⌄. Pressure was applied and the ⌄ continued. A health care practitioner ordered the resident to be sent to a	A 025		

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A 025	Continued From page 28 hospital. A 9:39 am facility note documented the resident returned at around 10:35 pm. During an interview on at 3:59 pm, the ADON said regarding the incident, she toileted and changed the resident. The ADON said she walked out first, and the resident was coming out right behind her. The ADON said she went to the trash can to the left of the bathroom then she heard a scream before she had a chance to open the door to the trash. She turned around and saw resident #9 screaming and saw the resident's in the jam of the door. The ADON said the resident was unable to say how it happened. The ADON said the resident's communication consists of mumbling in Spanish. The ADON said she got the resident's out and saw the resident's was . The ADON said she stayed with the resident while another caregiver retrieved gauze and called 911. The ADON said emergency medical services ( ) arrived and transported the resident to a hospital. The ADON then said, "because whenever you're done changing (the resident) she walks herself out, she likes to go out fast". The ADON was then asked for clarity who exited the bathroom first and she repeated that she exited first, went to the trash can then heard the resident scream. When the ADON was asked why she did not allow the resident to exit the bathroom first so she could be assisted out, the ADON replied "I did not think about that". The ADON said she now ensures there are two people in the bathroom while changing this resident and she is very cautious with the resident's . On at 10:05 am, resident #9 was seen sitting in a wheelchair in the dayroom. Her third	A 025		

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A 025	Continued From page 29 right [illegible] was [illegible], and the tip was [illegible]. On [illegible] at 11:37 am, the administrator said she completed the [illegible] incident report based on what the ADON reported. The administrator said she was not present at the time of the incident. On [illegible] at 5:40 pm during the exit conference the RN consultant said she disagreed with the findings regarding resident #9. When the surveyor repeated what the ADON said during her interview regarding the incident, the RN consultant, although not present during the incident, said the ADON was with the resident in the bathroom when the resident's [illegible] was crushed. The RN consultant then turned to the ADON and asked, "were you with her in the bathroom?" The ADON then looked at the surveyor and said "yes, I told you I was with her". The surveyor responded that what the ADON was saying now was not what she said during the interview. On [illegible] at 5:55 pm, the administrator said that in addition to what she documented on the incident report, which was for staff to ensure the resident's [illegible] remain free of door jams as doors are closing, she also verbally told staff to watch for the resident's [illegible] when assisting her out of the bathroom. The administrator said she did not document her conversations with staff. 2. A review of resident #8's record revealed a facility admission date of [illegible]. The resident's medical history included [illegible] type 2, [illegible] and [illegible]. The	A 025		

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A 025	Continued From page 30 resident required assistance with self-administration of medications. A review of the resident's , MOR revealed a health care practitioner's order for , 250 mg tablet take 1 tablet by twice daily for 4 days. The MOR had only one 8 am entry for the medication that was signed as given on , and . There was not another entry to indicate the resident received the medication twice daily as was prescribed. In addition, the resident's record did not contain facility documentation to explain the reason the medication was prescribed. On at 2:14 pm, the ADON was questioned about the findings and an opportunity was given to provide additional documentation but nothing else was provided. 3. Resident #17's record review revealed an admission date of . The 1823 Health Assessment dated listed medical history of , Multiple , , 's , history of , , right pubic , , and , . Resident #17 was identified as a high risk and ambulates with a walker. She needs assistance with activities of daily living (ADLs) bathing and . Supervision with ambulation, transferring and toileting. She needs assistance with self-administration of medications. On , the facility reported a incident that occurred resulting in resident #17 sustaining a to the left and a to right pubic .	A 025		

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A 025	Continued From page 31 There was no documented evidence of this noted in the facility notes as required. Furthermore, there was no documented evidence that any interventions were put in place per the facility's policies and procedures. On at 2:30 PM, an interview with the Administrator confirmed the findings. She stated that she could not find any other supporting documentation. 4. Resident #3's record review revealed an admission date of . The last 1823 Health Assessment dated listed diagnostic codes for medical conditions. She needs supervision with activities of daily living (ADLs) bathing, , and grooming and independent with eating, ambulation, toileting and transferring. She needs assistance with self-administration of medications. Resident #3 was recently admitted on to Hospice care. A review of resident #3's log and documented for at (pounds), and next due in at . Resident #3 had a significant in the last six months. There were no facility notes that the facility notified the physician, family, and Hospice of the significant loss. On at 3:30 PM, an interview with the Administrator confirmed the findings. She further stated that she looked for any other documentation to support at least letting Hospice know but could not provide.	A 025		

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A 025	Continued From page 32 5. Resident #11's record review revealed an admission date of . The 1823 Health Assessment dated listed medical history of Severe , High , and . He has limited communication. He is independent with ambulation, , bathing, eating, and transferring and supervision with grooming and toileting with activities of daily living (ADLs). He needs assistance with self-administration of medications. A hospital record dated revealed that he went to the hospital for for refusing to take his medications. There were no facility notes documenting this hospitalization and no other documented evidence if resident #11's physician and legal representative (Guardian) was notified. On at 2:45 PM, an interview with the Administrator confirmed the finding. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident	A 032		

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A 032	Continued From page 33 has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,	A 032		

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A 032	Continued From page 34 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, resident record review and interview, the facility failed to make a daily effort to ensure that 1 of 14 sampled residents (#3) had an identification bracelet listing the name of resident, name of the facility, address of the facility and telephone number of the facility on their person after being identified as an elopement risk resident as required. Findings: Resident #3's record review revealed an admission date of . The last 1823 Health Assessment dated listed diagnostic codes for medical conditions. She needs supervision with activities of daily living (ADLs) bathing, , and grooming and independent with eating, ambulation, toileting and transferring. She needs assistance with self-administration of medications. Resident #3 was recently admitted on to Hospice care. Resident #3 was also listed as an elopement risk. An observation on at 1:45 PM, resident #3 did not have an identification bracelet on her person or not in her room. Further observation	A 032		

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A 032	Continued From page 35 revealed the identification bracelet was not on her wheelchair. A review of the facility's elopement policy only documented what to do if a resident should go missing. There was no documentation regarding procedures of an elopement to include making a daily effort checking for an identification bracelet on an elopement risk resident as indicated in the state regulations. On at 2:25 PM, an interview with the registered nurse consultant providing today's copy of the census with dots documented on it, that indicated this was their (facility's) daily effort checking all elopement risk residents had their identification bracelets on their persons. It was explained that the agency needed to review for the month of and prior months to ensure checks were done. (Photographic Evidence Obtained) On at 2:35 PM, an interview with the Administrator confirmed the findings. Class III	A 032		
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	A 054		

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A 054	Continued From page 36 use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure the medication observation record (MOR) was free of omissions for 7 of 14 sampled residents who received assistance with self-administration of medication. (#3, #7, #8, #9, #11, #12, #13). Findings: 1. A record review of Resident #7 revealed an admission date on [illegible]. A health assessment form (1823) dated [illegible] indicated a medical history of Acute [illegible], [illegible], Par cytopenia, [illegible], Wernicki S, [illegible], ST	A 054		

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A 054	Continued From page 37 Memory Loss, Forgetful, Nursing for medical and medication management and needs assistance with self-administration. On at 11:00am a review of resident #7 Medication Observation Records for , revealed omissions in the MORs for the following: 1 MG tab give one table by once a day at 8am was not documented as administered on , , , , , , , , , , , and . 10 GM/15ML SOLN take two tablespoonsful (30ml) by three times a day at 8am was not document as administered on , , , , , , , , , , , , and . was not documented as administered for the 12pm dose on , , , , , , , , , , , , , , , , and . was not documented as administered for the 8pm dose on , , , , , , , , , , , , and . 5 MG tabs take one tablet by at bedtime at 8pm was not documented as administered on , , , , , , , , , , , , , and . Multi- with take one tablet by once a day at 8am was not documented as administered on , , , , , , , , , , , and . SOD DR 40 MG take one tablet by two times before meals was not documented as administered at 7am on ,	A 054		

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A 054	Continued From page 38	A 054		

, , , , , , , , , , and .
SOD DR 40 MG at 4pm was not documented as administered on , , , , , , , , , , , and .
B-1 100 MG Tablet one tablet by once a day at 8am was not documented as administered at 8am on , , , , , , , , , , , and .

On at 11:00am a review of resident #7 Medication Observation Record for , revealed omissions in the MORs for the following:

1 MG tab give one table by once a day at 8am was not documented as administered on , , and .

10 GM/15ML SOLN take two tablespoonsful (30ml) by three times a day at 8am was not document as administered on , , and was not documented as administered for the 12pm dose on , , , and was not documented as administered for the 8pm dose on and .
5 MG tabs take one tablet by at bedtime at 8pm was not documented as administered on and
Multi- with take one tablet by once a day at 8am was not documented as administered on , , and .
, SOD DR 40 MG take one tablet by two times before meals was not documented as administered at 7am on , , and SOD DR 40 MG at 4pm was not documented as administered on

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A 054	Continued From page 39	A 054		

and .

B-1 100 MG Tablet one tablet by once a day at 8am was not documented as administered on , , and .

On at 2:36pm The Administrator stated there are no notes for Resident #7.

2. A record review of Resident #13 revealed an admission date on . A health assessment form (1823) dated indicated a medical history of 's, , Major Order, , and , Decreased function, diagnosis and needs assistance with self-administration.

On at 11:30am a review of resident #13 Medication Observation Records for , revealed omissions in the MORs for the following:

10 MG Tablet take one tablet by in the evening at 6pm was not documented as administered on , , , , , , , , , and .

2 MG Caps take one capsule by twice a day at 8am was not documented as administered on , , , , , , , , , , , , and , 2 MG Caps at 5pm was not documented as administered on , , , , , , , , , and .

0.5 MG Tabs take one-half tablet (0.25MG) by two times a day at 8am was not administered on , , , ,

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A 054	Continued From page 40 , , and , 0.5 MG Tabs was not documented as administered for the 5pm dose on , , , , , , , , , and . Tablet take one tablet by once a day at 8am was not documented as administered on , , , , , , , , and . 50 MG take one tablet by twice a day at 8am was not documented as administered on , , , , , , , , , , and at 5pm was not documented as administered on , , , , , , , , and . 150 MG take one tablet by at bedtime at 8pm was not documented as administered on , , , , , , , , , and . D3 2,000 Unit take one tablet by once a day at 8am was not documented as administered on , , , , , , , , and . 220 MG take one capsule by once a day at 8am was not documented as administered on , , , , , , , , , and . On at 11:30am a review of resident #13 Medication Observation Records for , revealed omissions in the MORs for the following: , 10 MG Tablet take one tablet by	A 054		

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A 054	Continued From page 41 . . . . in the evening at 6pm was not documented as administered and . , 2 MG Caps take one capsule by . . twice a day at 8am was not documented as administered on , and . . , ... 2 MG Caps at 5pm was not documented as administered on and . Tablet take one tablet by once a day at 8am was not documented as administered on and . . , 50 MG take one tablet by . . . twice a day at 8am was not documented as administered on , , and . . . . . , 50 MG take one tablet by . . . twice a day at 5pm was not documented as administered on . . . . . and . . . . 150 MG take one tablet by . . . at bedtime at 8pm was not documented as administered on . . . . . and . . . . D3 2,000 Unit take one tablet by . . . once a day at 8am was not documented as administered on . . . . . , ... , and . . . . 220 MG take one capsule by . . . once a day at 8am was not documented as administered on . . . . . , ... , and . . . . . A review of the facility's Medication Policy dated states, giving medication directly to the resident at the time the medication is to be taken. On . . . . . at 12:35pm Staff A stated the system was offline on , and 4. I did not do a paper MOR. I know I gave the meds, maybe I didn't click off it. I really can't remember.	A 054		

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	AL11922279	A. BUILDING: _____ B. WING _____	02/06/2024

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A 054	Continued From page 42 Sometimes the internet goes off a lot. The Administrator or Nurse probably has the paper MOR. The pharmacy provides the MORs, and they just came last month sometime. On at 1:00pm Staff D stated the internet goes slow. Sometimes you have to go in and out of the system. You can't sign the MORs until the internet comes up. On , and 4, that's what I'm telling you. I could not sign the MORs because the internet did not come up. There is no policy to tell you what to do when the internet is down. We normally just tell the nurse. I'm able to see the residents and their medications when the system is down. I just can't update the MORs that they received it. No, I don't go if I didn't click off on the prior med pass. Yes, I can go but I just move on. On at 1:30pm The Assistant Director of Nursing (ADON) stated the discharged meds go to the pharmacy each day. I document it on the log and the nurse checks it. We count the number of pills left that are returned to the resident. No medication was returned to the pharmacy, and everything has been completed for resident #7. On at 2:08pm The Administrator stated there is a policy in place when the power goes out. I know there's one for hurricanes, not sure about the internet. I will go look for the policy. On at 4:45pm The Administrator stated we are to call the pharmacy to get paper MORs when we're unable to document electronically. We do not have a policy in place for when to contact the pharmacy. The pharmacy	A 054		

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A 054	Continued From page 43 typically can create the MORs automatically if we call them and they will send right over. A review of the facility's revised Internet Outage Policy Statement states, "Staff shall maintain an alternate method for staff to document resident medical information when the Facility experiences an outage of the internet system. During the Downtime of loss of internet or loss of power. When an unscheduled Downtime occurs, staff must contact the Administrator and/or the Director of Nursing, or designee. System Downtime Documentation, for downtime lasting more than 4 hours or sooner, based on the medication administration time, a paper Medication / Treatment Administration record will be used for documentation. All other documentation will be done on paper until the system is restored. If the downtime is related to internet outage, all documentation will be on paper as detailed above. In the event the electronic medical record is not functioning paper will be initiated until system is brought up. Ensure that all information recorded on paper during the downtime gets filed in the resident's chart. 3. A review of resident #8's record revealed a facility admission date of . The resident's medical history included type 2, and . The resident required assistance with self-administration of medications. A review of the resident's and MORs revealed medications were not signed as given on and . (photographic	A 054		

Agency for Health Care Administration

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A 054	Continued From page 44 evidence obtained) 4. A review of resident #9's record revealed a facility admission date of . The resident's medical history included severe , , and . The resident required assistance with self-administration of medications. A review of the resident's and MORs revealed medications were not signed as given on , , , , , and . (photographic evidence obtained) The MORs nor facility notes for either resident documented the reason for the omissions. (photographic evidence obtained) On at 2 pm, Med tech D said the omissions in the MORs may be as a result of the internet being down, causing the inability to sign them. On at 2:09 pm the findings were discussed with the administrator. The administrator was then asked if the facility had a policy on charting medications if the internet was down. The administrator said she would check. On at 4:35 pm, the administrator said there was no such policy then said the staff were expected to call the pharmacy to request a paper MOR. 5. Resident #3's record review revealed admission date . The last 1823 Health Assessment dated listed diagnostic codes for medical conditions. She needs supervision with activities of daily living (ADLs) bathing, , and grooming and independent with eating, ambulation, toileting and transferring.	A 054		

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A 054	Continued From page 45 She needs assistance with self-administration of medications. Resident #3 was recently admitted on [redacted] to Hospice care. A review of the [redacted] Medication Observation Record (MORs) revealed holes (missing) indicating that staff did not sign off on dates [redacted] and for all her medications [redacted] 250 milligrams (mg), [redacted] 25mg, 50mg, [redacted] D 50mcg, and [redacted] 220mg. The [redacted] MORs review revealed holes (missing) for the following medications listed below: a. [redacted] 250 mg on dates [redacted] and [redacted]. b. [redacted] on dates [redacted] and [redacted]. c. [redacted] 25 mg on dates [redacted] and [redacted]. d. [redacted] 50 mg on dates [redacted] and [redacted]. e. [redacted] D 50 mcg dates [redacted] and [redacted]. f. [redacted] 220 mg dates [redacted] and [redacted]. On [redacted] at 12:35 PM, an interview with staff A stated the system was offline on [redacted] and 4th when she worked over the weekend and did not complete a paper MORs. She confirmed that she gave the medications but maybe didn't	A 054		

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A 054	Continued From page 46 click off it. She could not really remember and sometimes the internet goes off a lot. On at 1 PM, an interview with the Administrator confirmed the findings and further stated that the facility did not do paper MORs in the event of the electronic MORs cannot be accessed or offline. 6. Resident #11's record review revealed admission date . The last 1823 Health Assessment dated listed medical conditions Severe 's , High and . He needs supervision with activities of daily living (ADLs) grooming and toileting, and he is independent with eating, ambulation, transferring, bathing, and . He needs assistance with self-administration of medications. A review of the Medication Observation Record (MORs) revealed holes (missing) indicating that staff did not sign on dates - for all his medications: 81mg; 10mg; Fish oil 360mg; 10mg; , 50mg; D3 2000mg and 220mg. The MORs review revealed holes (missing) for the following medications listed below: a. 81 mg dates , , , , and . b. 10 mg dates - , , and . c. Fish Oil 360 mg dates , ,	A 054		

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A 054	Continued From page 47 , , and . d. 10 mg dates - ; , , and . e. dates - ; , and . f. 50 mg dates - g. D3 2000 mg dates , , , and . h. 220 mg dates - ; - ; , , and . On at 12:35 PM, an interview with staff A stated the system was offline on , and 4th when she worked over the weekend and did not complete a paper MORs. She confirmed that she gave the medications but maybe didn't click off it. She could not really remember and sometimes the internet goes off a lot. On at 1 PM, an interview with the Administrator confirmed the findings and further stated that the facility did not do paper MORs in the event of the electronic MORs cannot be accessed or offline. 7. Resident #12's record review revealed admission date . The 1823 Health Assessment, not dated, listed medical history of with agitation, Major , , diffuse , and mastopathy of unspecified . She needs supervision with bathing, , and grooming. Independent with ambulation, eating, toileting and transferring. She needs assistance with self-administration of medications.	A 054		

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A 054	Continued From page 48 A review of the Medication Observation Record (MORs) revealed holes (missing) indicating that staff did not sign off on dates for all her medications: 500 mg for 7 days ordered on missing ; 10 mg; 1 mg; 3 mg; ; 50 mg; Rosuvastatin 5 mg; 100 mg (new); D 50 mcg and 220 mg. The MORs review revealed holes (missing) for the following medications listed below: a. 500 mg for 7 days, for first 3 days effective on and . b. 10 mg dates - ; and . c. 1mg dates - ; and . d. 3 mg dates - ; and . e. 10 mg dates - ; and . f. dates - ; - ; and . g. 25 mg dates - ; - . h. Rosuvastatin 5 mg dates - ; - ; and . i. 50 mg dates , ,	A 054		

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A 054	Continued From page 49 . . . . . - . . . . . ; . . . . . , ... , - . . . . . and . . . . . . j. . . . D 50 mcg dates . . . . . - . . . . . ; - . . . . . ; . . . . . , ... - . . . . . and . . . . . . k. D3 25 mg dates , ... - . . . . . ; . . . . . , - . . . . . . l. . . . 220 mg dates . . . . . - . . . . . ; . . . . . - . . . . . ; . . . . . , ... - . . . . . and . . . . . . On . . . . . at 12:35 PM, an interview with staff A stated the system was offline on , and 4th when she worked over the weekend and did not complete a paper MORs. She confirmed that she gave the medications but maybe didn't click off it. She could not really remember and sometimes the internet goes off a lot. On . . . . . at 1 PM, an interview with the Administrator confirmed the findings and further stated that the facility did not do paper MORs in the event of the electronic MORs cannot be accessed or offline. (Photographic Evidence Obtained) Class III	A 054		