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
	AL11964968	A. BUILDING: _____ B. WING _____	C 03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOME PLACE LIKE HOME,INC.	7819 N GLEN RD JACKSONVILLE, FL 32211

(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 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;	A 055		

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A 055	Continued From page 1 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the	A 055		

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A 055	Continued From page 2 resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure discontinued medication for one of four residents was separated from current medications to avoid distribution during assistance with self-administration of medication. The findings include: On Resident #2 was observed at 10:00 AM receiving medications from Employee C, Caregiver/ Medication Technician. Employee C assisted the resident with , , , and . Review of the Medication Observation Record (MOR) revealed the resident received , , 5mg/gm, Thera tears Solution , , (OP), and ACET OP 1% Suspension daily. (Photographic evidence obtained) The label on the vial for the , , 5mg/gm read: Instill into lower , of , (L) four times a day for 10 days and was filled in (Photographic evidence obtained). Review of Resident #2's record revealed an order to discontinue the , , , medication dated . A letter from Resident #2's Ophthalmologist's office dated .	A 055		

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A 055	Continued From page 3 included the . . , . . . , . . in a medication list. (Photographic evidence obtained). Review of the , and MORs revealed the staff had been assisting the resident with the , , , medication from the time it was discontinued on . . . . . and before the new order on was obtained. (Photographic evidence obtained). On . . . . . at 5:40 PM during an interview with the Administrator she stated she was unaware of the order to discontinue the , , , for Resident #2. Class III	A 055		
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 . . . . . examination requirement. An	A 078		

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A 078	Continued From page 4 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, 2. Maintain time sheets for all staff.	A 078		

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A 078	Continued From page 5 (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 employee record review and staff interview, the facility failed provide evidence that one of three sampled employees had a negative examination (Employee B). The findings include: Record review for Employee B, Caregiver/Med Tech, showed a hire date of . . . . . No evidence was found in the record to show a . . . . . examination was conducted on Employee B. During an interview with the Administrator on . . . . . at 2:15 PM, she stated that Employee B's personnel records were not all at this location. The complete record was at one of her other facilities. The items missing from Employee B's file were listed for her but the proof of a negative examination was not provided prior to the end of the survey. Class III	A 078		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural,	A 152		

Agency for Health Care Administration

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A 152	Continued From page 6 mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that empty tanks for one of four residents of the facility were secured in a safe manner to prevent hazards. The findings include:	A 152		

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A 152	Continued From page 7 On at 10:00 AM, an observation of the restroom next to Resident #4's bedroom revealed 8 ,, tanks standing upright on the floor next to an empty blue plastic storage crate that would store 8 tanks (Photographic evidence obtained). The administrator confirmed the tanks were empty and that staff stored tanks this way. She explained, "the full ones are kept in the crate and the empty ones, they store here." She did not explain why the empty tanks were not stored securely in the crate. On at 11:40 AM, during an interview with a third party hospice representative, he stated that the ,, tanks were to be stored in the blue crate for safety whether they were empty or full. He was going to bring them another crate so they could properly store the tanks when they were empty. He confirmed that the empty tanks and the full tanks could be stored together in the blue crate because he only delivers 8 per week and the crate only holds 8 tanks. During an interview with the daughter of Resident #4 on at 4:40 PM, she confirmed her mother was prescribed 2 liters (L) of ,, continuously. The staff asssited with keeping her ,, concentrator on while she was in bed and used the tanks when she was up in her wheelchair. Review of the record for Resident #4 revealed a physician's order for ,, at 2 liters per minute (Photographic evidence obtained). Review of a facility memorandum with the subject: [Facility name] Care Plan Meeting revealed staff were assisting with Resident #4's ,, that was delievered by the	A 152		

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A 152	Continued From page 8 hospice provider (Photographic evidence obtained). Review of the facility policy and procedure titled , , revealed no information about how to store , , tanks safely (Photographic evidence obtained). Class III	A 152		
CZ830 SS=F	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving	CZ830		

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CZ830	Continued From page 9	CZ830		

provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.
(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the state of emergency.
2. Is currently licensed.
3. Does not have a provisional license.
4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.
(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end

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CZ830	Continued From page 10 of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on facility document review and staff interview, the facility failed to ensure their Comprehensive Emergency Management Plan (CEMP) was submitted on an annual basis. The plan is applicable to all residents of the facility. The findings include: On at 9:39 AM, the facility's CEMP was requested from the Administrator. The administrator stated she would get it, but it was not produced before the end of the day. On at 12:02 pm the CEMP was e-mailed by the Administrator. Attached to the e-mail was a letter on facility letterhead that read: CEMP was submitted on and approved on . CEMP was submitted on and we have not received approval yet. Photographic evidence obtained. Class III	CZ830		

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A 000	Initial Comments A relicensure survey was conducted at Some Place Like Home Assisted Living Facility on /2024. The facility had deficiencies at the time of the survey.	A 000		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure there was a physician's order, a care plan, and an annual	A 033		

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A 033	Continued From page 12 review for the use of a [redacted], for one of four residents, Resident #4's. The findings include: On [redacted], Resident #4 was observed lying in her bed at 10:00 AM. Her [redacted] were open and she was quietly speaking to Employee C, Caregiver and Medication Technician. Her bed had full bed rails with foam cushions applied with tape around each of the rails. Employee C stated that the resident moves around a lot in the bed and the foam was padding so she would not hurt herself if she banged up against the rails. She stated she needed the rails or she would [redacted] out of bed. She confirmed the resident couldn't independently lower the bed rails. Review of Resident #4's record revealed she was admitted to the facility on [redacted]. Further review of the record revealed no order for bed rails on her bed, no annual review of the appropriateness for the continued use of the bed rails by the resident's physician, and no care plan for the use of the bed rails. On [redacted] at 1:55 PM, Employee C stated that she was not sure if there was a physician's order for the bed rails on Resident #4's bed. She looked through the record and the hospice provider's chart and did not find one. She stated, "I don't think we have one." On [redacted] at 2:15 PM, the Administrator stated that she looked for the physician's order for bed rails for Resident #4 and could not find one. She stated she thought she had one but could not find it. She confirmed that Resident #4 was [redacted] and did not understand how to independently lower the bed rails.	A 033		

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A 033	Continued From page 13 On at 2:16 PM Employee E, Manager of a sister facility, who was visiting the facility, stated that she called the hospice provider and requested that they fax over a physician's order for the bed rails for Resident #4. During an interview on at 4:40 PM with Resident #4's daughter, who served as Power of Attorney/Guardian, stated that her mother needed the bed rails on her bed. "If she didn't have them she'd out for sure." She added that, "she . . . . . very easily. I want them on the bed." Class III	A 033		