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
	AL11968677	A. BUILDING: _____ B. WING _____	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING GRACE ASSISTED LIVING HOME II, LLC	2257 EDGEWATER DRIVE WEST PALM BEACH, FL 33406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Amended Report An unannounced Relicensure and Generator Monitoring survey was conducted at Amazing Grace Assisted Living Home II, LLC. on . The provider had deficiencies at the time of the visit.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section	A 054		

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A 054	Continued From page 1 429.41, 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 records review and interviews, it was determined that the facility failed to ensure that staff signed the medication observation record (MOR) after assisting residents with self-administration of medications for, 2 of 6 sampled residents (Resident #2 & Resident #4). The findings included: On at 9:20 AM, it was noted that Resident #2's MOR and Resident #4's MOR had missing signatures, for the morning medications. Review of Resident #2's health assessment (AHCA form 1823) dated revealed that a diagnosis of among others. Resident #2 required assistance with self-administration of medication. Review of Resident #4's AHCA form 1823 dated documented that Resident #4 diagnoses included, . Resident #4 received hospice services and required assistance with self-administration of medications. At 2:00 PM on , after staff A assisted Resident #1 with self-administration of his medication, Staff A was asked why there were missing signatures on the MOR. Staff A, a certified nursing assistant (CNA), reported that she started working at 8:00 AM, but it was the night shift staff (Staff C) who assisted the residents with self-administration of medications,on that day. She was not aware that	A 054		

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A 054	Continued From page 2 the MOR had missing signatures. At 2:30 PM, the Administrator was also informed about the missing signatures in the MOR. The Administrator assumed that the resident might have refused to take the medications. Then, she later said, it could be that an order was given to withhold the medications. However, there were no indication or notes on the MOR that noted this reason. At 3:02 PM on a Phone interview with Staff C confirmed that she assisted residents with taking their medications the morning of . Staff C said that in that morning, the Nurse Practitioner visited Resident #2 early and was told that Resident #2 did not have a good night. He was not feeling well. So the Nurse Practitioner ordered withholding Resident #2 medications, for that morning. Staff C said she forgot to note that on the MOR. Additionally, she said that she also did not give Resident #4 her prescribed medication because Resident #4 had refused to take it. Staff C said that she told Staff A to give the medication to Resident #4. In a follow-up interview on at 3:45 PM, Staff A confirmed that she did give Resident #4 her prescribed medication. She said since it was an , she had to make sure that Resident #4 take the medication as ordered for the duration of the time. Staff A said, she forgot to sign the MOR. The findings were discussed with the Administrator during the Exit meeting on at 4:12 PM. The Administrator acknowledged the findings and said she will implement the necessary corrective actions.	A 054		

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A 054	Continued From page 3 Class III	A 054		