

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2025
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NAME OF PROVIDER OR SUPPLIER

ARLINGTON ADULT RESIDENTIAL FACILITY INC

STREET ADDRESS, CITY, STATE, ZIP CODE

**6300 ARLINGTON EXPY.
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 000	Initial Comments An abbreviated relicensure survey with Limited Mental Health Monitoring was conducted at Arlington Adult Residential Facility, Inc. from through The facility had deficiencies at the time of the investigation.	A 000		
A 025	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	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (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 observation, interview, and record review, the facility failed to ensure supervision was provided to 6 of 21 sampled residents (Resident #2, #6, #14, #17, #20, #21.) Staff failed to provide supervision to residents who required monitoring, and failed to initiate actions to ensure care and services were provided to a resident who left the facility unsupervised and did not return. The findings include: 1. Review of the facility's admission log showed Resident #2 was admitted on . Based on	A 025			

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A 025	Continued From page 2 an 1823 health assessment signed on her diagnoses included: Type 2 medication non-compliance, poor memory and . She had " mobility secondary to poorly controlled " Resident #2 required supervision for all activities of daily living. She required assistance with medication administration, which was documented on page 1 and page 3 of the assessment. Special precautions listed that she was "forgetful." Photographic evidence obtained. On at 9:24am, Resident #2 was observed conducting a check in an unsupervised area. The resident did not perform hygiene before or after the check. There were several clear Ziploc bags stored in a clear bin, with cards labeled with names and orders for monitoring, which contained residents' individual . The clear Ziploc bags were lined up in a clear plastic bin without a lid. The bin sat on a table which was open and able to be accessed freely. Next to the table there was a red sharps container, a metal garbage can, and a log book for residents to document their . Postings on the wall stated this area revealed it was also used for resident phone access, temperature checks, and monitoring. Photographic evidence obtained. Review of the facility's admission log showed Resident #6 was admitted to the facility on . Based on an 1823 health assessment signed on , his diagnoses included: and . Based on the 1823, Resident #6 needed assistance with self-administration of medication. Photographic evidence obtained.	A 025		

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A 025	Continued From page 3 On _____ at 9:49am, Resident #6 was observed conducting his _____ check without supervision. The resident did not perform _____ hygiene before or after the _____ check. The resident documented in the log book then exited the area. An interview regarding _____ was conducted with the Administrator on _____ at 2:46pm. He explained the _____ were not stored in the residents' rooms because they could get lost. He then added, "Or they would do their _____ everyday 8, 9, 10 times a day." He stated the _____ used to be stored in the secured area but it was moved to the lobby during COVID. He was asked about the supervision of the _____ use, and how they ensure residents were performing the task correctly. He responded, "We haven't had any issues." Review of the facility's admission log showed Resident #21 was admitted on _____. Based on an 1823 health assessment signed on _____ his diagnoses included: _____ type II, _____ and _____ Nursing/Treatment/ _____ Service Requirements listed medication management. Based on page 3 of the 1823 assessment, Resident #21 needed assistance with self-administration of medication. Photographic evidence obtained. On _____ at 3:02pm, Resident #21 was observed conducting his _____ check without supervision. The resident did not perform _____ hygiene before or after the _____ check. The resident documented in the log book	A 025			

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A 025	Continued From page 4 then exited the area. Review of the facility's admission log showed Resident #14 was admitted into the facility on . Based on an 1823 signed his diagnoses included: acute hypoxic failure and or Behavioral Status: Nursing/Treatment/ Service Requirements: symptom and medication management. Based on the 1823 Resident #14 needed assistance with self-administration of medication. On at 9:27am, Resident #14 was observed checking his without supervision. After completing the stick he placed the test strip to the he had pricked to collect a sample of . The monitor read "Er 3". He repeated the process. Again, the monitor read "Er 3". He was asked what that meant, but he did not answer. When asked what he did with the information on the , he grumbled, and his response was unintelligible. Resident #14 then reached for the logbook of resident and wrote his name, and "140." He was asked to verify whether that was his but he didn't answer. He stated he was not on . The resident did not perform hygiene before or after the check. An interview was conducted with Employee B, an unlicensed Medication Technician (Med Tech) on at 12:15pm. He stated that he had received the initial 6 hour training in assisting with self-administration of medications, and the annual 2 hour update training. He stated that he had also received training specific to the facility's medication process. He explained the process for	A 025		

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A 025	Continued From page 5 assisting residents with _____ included providing the resident the _____, and helping them set it up as needed. He confirmed the facility's process included residents taking their _____ readings independently in the lobby area, recording it on paper with their name and date for the Med Tech when they come for their medications. He was asked how accuracy of the information was confirmed. He stated that the _____ were checked "periodically." Staff make sure the residents have the _____ and "look at it to make sure they're putting the right dosage." He stated he had not received any training on injections and that it had been approximately a year since he had reviewed the inserts for the _____ or received training on proper use. On _____ at 12:44pm Employee B was asked to retrieve the _____ reading that Resident #14 received on _____. He was given the resident's _____, and Employee B pressed several buttons. He stated he was having difficulty. He presented the _____ reading from _____ and stated that was the last one the _____ would display. He retrieved the Medication Observation Record (MOR) and stated that the resident's _____ was 140; the resident had also documented the 140 on the log, but it was not on the _____. After advising Employee B of the observation of Resident #14 receiving an error message and documenting 140 incorrectly, he sighed and did not give a verbal response. Review of the facility's admission log showed Resident #20 was admitted on _____. Review of his _____ MOR revealed he received _____ tab 5mg for: _____.	A 025			

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A 025	Continued From page 6 tab 1000mg for: and tab 50mg for: On at 2:13pm Resident #20 was observed checking his without supervision. He did not perform hygiene before or after the check. 2. An interview was conducted on at 12:31pm with Employee A, a Med Tech. During the interview, she was asked if any residents had away from the facility. She responded that yes, Resident #17 was not there, and had left three weeks ago. She stated, "He always goes out. We report it to the case manager." On at 11:32am, the Administrator was asked to provide the 1823 health assessment and physician orders for Resident #17. He stated that Resident #17 had been discharged and was no longer in the facility, so he was asked to also provide the discharge information with the 1823 health assessment and physician orders. On at 1:42pm, the Administrator was asked about the information previously requested for Resident #17, including the 1823 assessment, orders, and discharge information. He provided the 1823 assessment and a blank medication observation record (MOR) which the pharmacy sent over, adding "it might or might not be correct." He was asked when the last time Resident #17 was in the facility, and he responded, "I think it was . He left. He got . He doesn't want to be here. I tried to get him . He doesn't want to come . I tried to get the case manager involved. Another staff member tried to get him to come so we	A 025		

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A 025	Continued From page 7 discharged him on _____. He continued with, "He's just out there in the streets. We tried to get him _____. He was _____ and released _____. He stated they tried to get JSO [Jacksonville Sheriff's Office] involved. He was asked again to provide a copy of the discharge notice for Resident #17, to which he replied, "There's no discharge notice. I want him to come _____ but he doesn't want to." The Administrator denied that this was an elopement, because "We know where he is. He's out there in the streets." On _____ at 3:59pm, the Administrator was asked if he had a location for Resident #17 and if he knew if he was getting his medications. He responded, "I don't have any idea. His medications are here." He stated the case manager was checking the jails and hospitals, and Resident #17 was not released to them after getting out of jail. He explained the process of leaving the premises included signing in and out. He then stated that Resident #17 was not missing according to JSO, and again denied this was an elopement because staff watched him exit the facility. The Administrator was again asked if he knew the location of Resident #17, to which he responded, "No, we don't know where he is now. Several people have seen him. We discharged him on _____. He was asked to clarify this, and he explained, "We didn't get paid so we discharged him." Again, he was asked to provide a copy of the discharge notice. He stated, "We don't do a discharge notice. Because if he comes _____ I'll let him _____ in. He's not a missing person. If I call JSO they'll say he's not a missing person." He again confirmed that all of the resident's medications were at the facility, including his state identification card and his medical insurance cards. He also confirmed that he didn't have a physical location or any possible contacts for the	A 025			

AHCA Form 3020-0001
STATE FORM

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A 036	Continued From page 9	A 036			
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in nonintact skin, and mucous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide services in a manner that reduced the risk of transmission of , by failing to ensure that 1) Handwashing/sanitation occurred before/during/after levels were checked and was self-administered, and were cleaned after each use for five (Residents #2, #6, #21, #14 and #20) of 13	A 036			

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A 036	Continued From page 10 residents who required _____ testing, and 2) Resident #23's _____ equipment was not left in the facility's main lobby where other residents had access to it. The findings include: On _____ at 9:24 a.m., Resident #2 was observed checking her _____ using a _____ _____ stored in the lobby area of the facility. She used a _____ which was stored in a plastic bag, in a communal bin with other bags of _____, which contained resident names and _____ monitoring orders. A sharps container was sitting on a table, as well as a trashcan. During the observation of Resident #2 using her _____, she was not observed washing or sanitizing her _____ prior to, during, or after completing this task. On _____ at 9:49 a.m., Resident #6 was observed completing his _____ check without supervision. He used a _____ stored in a plastic bag, retrieved from the bin where the other bagged _____ were stored. He documented his _____ reading in the log book on the table and left the area. He was not observed washing or sanitizing his _____ prior to, during or after completing this task. On _____ at 3:02 p.m., Resident #21 was observed checking his _____ without supervision, using a _____ stored in a plastic bag in the bin with the other bags of _____. He stated he did this himself. He denied any concerns. He stated he wrote the number in the book (log on the desk) then told the staff at the window. He was never observed washing or sanitizing his _____ prior to, during or	A 036	

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A 036	Continued From page 11 after completing this task. During these observations, no staff were observed in the area to perform _____ cleaning or cleaning the area between resident use. An interview was conducted with the Administrator on _____ at 2:46 p.m. He was asked about the storage of the _____. He stated the _____ were not stored in the residents' rooms because they could get lost. He was asked who was responsible for cleaning the _____. He stated staff cleaned them "once or twice" and "sometimes it's at night." On _____ at 9:27 a.m., Resident #14 was observed checking his _____. He was not observed washing or sanitizing his _____ at any point prior to, during or after completing this task. At 11:00 a.m. on _____, the Administrator was asked about an _____ control policy, and he produced a binder containing a "Long-Term Care and Skilled Nursing Facility _____ and Prevention Control" Manual. Page 15-17 provided instructions for _____ washing. Page 3 - Long-Term Care Defined: "Long-Term Care facility" includes a nursing home, assisted living facility, adult family care home, board and care facility, or other similar residential adult care facility. Page 20-21 addressed "Cleaning and of Surfaces and Equipment." "All staff have a role in cleaning and _____ and should receive training as part of their orientation activities. _____ removes or kills germs that cause (or spread) _____. Both patient care items and environmental	A 036	

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A 036	Continued From page 12 surfaces should be cleaned and ." An interview was conducted with Employee B, a Medication Technician (Med Tech), on at 12:15 p.m. He stated he had received the initial six-hour training for assistance with self-administration of medication and the continual two hours of training. He further stated he had also received training specific to the facility's medication process. At 12:28 p.m., Employee B was asked how he assisted Resident #2 with her today. Among other steps taken, he said he reminded her to use an . He stated he gave residents an wipe to wipe their before checking their . He confirmed that each resident checked their before self-administering . He then gave them their and made sure they dialed it to the right dosage. He was asked if the residents were washing their before/after checking their , or before/after self-administration of . He replied that he could not confirm that was occurring. When he was asked whether he did anything to the pen prior to dialing the dosage and helping Resident #2 with the needle, he replied, "no". When he was asked whether he had ever read any of the instructional inserts in the manufacturers' packaging, he said he had not read an insert in at least a year. At 12:44 p.m., when Employee B was asked about the facility's process for cleaning the , he stated the staff periodically checked the and cleaned them with once a week. He stated the residents used toilet paper to clean their bloody after they measured their own levels but that could get on the . He confirmed that there was no written schedule for	A 036			

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A 036	Continued From page 13 cleaning the devices. On at 1:25 p.m., several were observed covered in dark, reddish-brown matter which was also observed on the plastic bags housing the devices. During the observation of the area where were located, a machine with the piece, cord, and tubing intact was observed in the lobby. Resident #23's name was taped to the device along with a basket of supplies. At 1:32 p.m. on , the Administrator rushed over stating, "We forgot to take that in." He immediately picked up all of the supplies, removing them from the lobby. On at 2:23 p.m., Resident #20 was observed checking his in the facility's lobby using a from the communal storage bin. He was not observed washing or sanitizing his prior to, during or after completing this task. The was not cleaned after the process was completed. He was asked who was responsible for cleaning the . He replied, "I put it in the bag." On at 2:21 p.m., Resident #2 was interviewed. She was observed to be very . She confirmed she checked her own and received . She was asked who cleaned her , but she did not know. She put it in the bag. She was asked about hygiene and she shrugged her . A review of the manufacturers' instructional inserts for all residents receiving in the facility revealed the following instructions related to cleaning/sanitizing processes:	A 036			

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A 036	Continued From page 14 According to the _____ manufacturer's instructions accessed at US22LV00014_LEV_ _____ Quick_Guide.pdf on _____ at 10:45 a.m., the following should be adhered to: - Wash your _____ with soap and water. - Wipe the rubber stopper with an _____ swab. - Give your injection after wiping the injection site with an _____ swab and letting it dry. - 1. Wash _____ with soap and water. Wipe the rubber seal with an _____ swab. _____ 100 units/ml - Wipe the rubber seal with an _____ swab. Lispro _____ 100 units/ml - 1. Wash your _____ with soap and water. - 1. Wash your _____ with soap and water. Wipe the rubber stopper with an _____ swab. (Photographic evidence of all inserts obtained) CLASS III	A 036			
A 052	429.256(_____); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph,	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2025
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A 052	Continued From page 15 an syringe that is prefilled with the proper dosage by a pharmacist and an that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or	A 052		

Agency for Health Care Administration

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A 052	Continued From page 16 crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be _____ or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with	A 052			

Agency for Health Care Administration

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A 052	Continued From page 17 self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,	A 052	

Agency for Health Care Administration

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A 052	Continued From page 18 or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to follow proper procedures for 13 of 13 residents sampled who were meant to receive assistance with self-administration of medication (Residents #2, #6, #8, #9, #10, #11, #12, #13, #14, #15, #16, #18 and #19). The findings include: On at 9:24 a.m., Resident #2 was observed checking her in an unsupervised area. She used a which was stored in a plastic bag, in a bin with other bags of which contained resident names and monitoring orders. A sharps container was sitting on a table along with a log book for the residents to document their readings. During the observation of Resident #2 using her, she was not observed washing or sanitizing her prior to, during, or after completing this task.	A 052			

Agency for Health Care Administration

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A 052	Continued From page 19 A review of Resident #2's 1823 revealed diagnoses including Type II (poorly controlled), of both lower extremities, medication noncompliance, state, elopement risk, forgetful, and . Resident #2 needed assistance with medication administration. The 1823 was dated and signed by an APRN (Advanced Practice Registered Nurse) on . A review of the MOR (medication observation record) revealed that Resident #2 was prescribed 25 units under the skin every morning, as well as 5 mg (milligram) tabs 1 PO (by) QD (daily) for . The manufacturer's instructions accessed at US22LV00014_LEV_Quick_Guide.pdf on at 10:45 a.m., stated the following should be adhered to: Wash your with soap and water. Read the label to ensure you have the right . Pull off the pen cap. Make sure the is clear and colorless. Wipe the rubber stopper with an swab. Pull off the protective tab from the needle. Screw the needle tightly onto your . Make sure the needle is straight. Pull off the big outer needle cap. Pull off the inner needle cap and throw it away. Prime your pen by performing an air shot. Turn the dose selector to select 2 units. Holding your pen with the needle pointing up, tap the cartridge gently with your a few times to make any	A 052			

Agency for Health Care Administration

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A 052	Continued From page 20 air bubbles collect at the top of the cartridge. Press and hold the push button. Make sure a drop of _____ appears at the needle tip. Select your dose by turning the dose selector to the number of units you need to inject. Be careful not to push the push button as _____ will come out. Give your injection after wiping the injection site with an _____ swab and letting it dry. Keep the needle in the skin for at least six (6) seconds while continuing to depress the push button. Keep the button depressed until the needle is removed. Remove the needle and place it in the sharps container. Replace the pen cap on the _____ and store the pen without a needle attached. Photographic evidence obtained. On _____ at 9:49 a.m., Resident #6 was observed completing his _____ check without supervision in the same area. He documented his _____ reading in the logbook on the table and left the area. He was not observed washing or sanitizing his _____ prior to, during, or after completing this task. A review of Resident #6's 1823 health assessment revealed diagnoses including _____, general _____, and _____. He required assistance with self-administration of medications. The 1823 was dated and signed by the APRN on _____. A review of the _____ MOR revealed that among other medications, Resident #6 was receiving _____ 100 U/ml (units per milliliter) - inject under the skin four times a day	A 052			

Agency for Health Care Administration

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A 052	Continued From page 21 before meals and bedtime. Use SS (), and 100 U/ml - inject 16 units under the skin every night at bedtime. Photographic evidence obtained. The insert for 100 units/ml provided the following instructions: Pull off the pen cap. Be sure that the is clear. Do not use if the is cloudy, colored or contains particles. Wipe the rubber seal with an swab. Take a new needle and peel off the protective seal. Keep the needle straight and screw it onto the pen until fixed. Do not over-tighten. Pull off the outer needle cap. Keep this for later. Pull off the inner needle cap and throw it away. Do a safety test by selecting two units to make sure you have the correct dose. Select two units by turning the dose selector until the dose pointer is at the "2" mark. Press the injection button all the way in. When comes out of the needle tip, your pen is working correctly. You may need to repeat this up to three times before seeing . If no appears after the third time, the needle may be blocked. Change the needle and repeat the process. Do not use the pen until you see the . Do not select a dose or press the injection button without a needle attached. The insert for gave the following instructions: Wash your with soap and water. should look white and cloudy after mixing. Pull off the pen cap. Gently move the pen up and down twenty times (invert) so the glass ball moves from one end of the cartridge to the other.	A 052			

Agency for Health Care Administration

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A 052	Continued From page 22 Repeat moving the pen until the liquid appears while and cloudy. Do not use if the liquid appears discolored or has particles in it. For every following injection, move the pen up and down at least 10 times until the liquid appears white and cloudy. After mixing complete the following steps. If there is a delay, the will need to be mixed again. Wipe the rubber stopper with an swab. There must be at least 12 units left in the pen to be sure it is evenly mixed. If there is less than 12 units, use a new pen. Remove the protective tab from the disposable needle. Screw the needle tightly onto your . Pull off the outer needle cap. Pull off the inner needle cap and dispose of it. Before each injection, small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to get the right dose, turn the dose selector to 2 units. Hold your pen with the needle pointing up. Tap the cartridge a few times to make the air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to zero. A drop of should appear at the needle tip. If not, change the needle and repeat the process not more than 6 times. If you do not see the after 6 times, do not use the pen. Photographic evidence obtained. On at 9:49 am, Employee A was observed providing Resident #6 assistance with self-administration of 12 oral medications. She initiated the MOR, indicating the medication had been taken, after each pill was popped into the cup and prior to passing the pill cup to the	A 052			

Agency for Health Care Administration

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A 052	Continued From page 23 resident and confirming that Resident #6 had taken them. The MOR's entries for monitoring contained dashes (no numbers) on all but three 11am readings, and all but 3 of the 4pm entries for , 2025. Employee A did not orally advise what the medications were. On at 9:55 am, Employee A was observed preparing Resident #13's medications. He was ordered , 10mg three times a day. She put the 2pm dose in a cup, sealed it, initialed the MOR that he took the , and provided the makeshift package to Resident #13. She explained she did this because he was leaving. Employee A did not orally advise what the medications were. Resident #2 was observed receiving assistance with self-administration at 10:01 a.m. on . Employee A was observed popping 3 tablets into a cup and initialing the MOR they had been taken, prior to Resident #2 receiving the medications. Employee A did not orally advise what the medications were. During this observation, Employee A asked Resident #2 what her , reading was, and documented it in the MOR. Employee A was not observed assisting Resident #2 with the or verifying the reading. She documented this reading on the MOR's 11am timeslot. Resident #2's MOR showed the order was to have her checked before meals and at bedtime; times were 8am, 11am, 4pm, and 8pm. There were only dashes (no numbers) in all the 4pm and 8pm slots in ; the 8am slot only had one recording on , all others were just dash marks. Only the 11am entries were filled in.	A 052		

Agency for Health Care Administration

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A 052	Continued From page 24 On at 10:03am, Employee A was observed preparing Resident #8's medications. Employee A prepared 7 medications for Resident #8 and prefilled the MOR prior to Resident #8 receiving the medications. Employee A did not orally advise what the medications were. Resident #9 received one tablet from Employee A at 10:07 a.m. on . The MOR was filled in before Resident #9 received the medication. Employee A did not orally advise what the medications were. On at 10:08 a.m., Employee A was observed preparing Resident #10's medications and prefilling the MOR before offering them to the resident. Employee A did not orally advise what the medications were. He was due to receive 4 medications, including 600mg. Employee A prepared 3 medications but not the . Without offering him the medication, she documented that he refused his , stating he didn't like to take it. Resident #11 received 3 tablets from Employee A at 10:13 a.m. on . The MOR was filled in before Resident #11 received the medications. Employee A did not orally advise what the medications were. Resident #12 received 11 medications from Employee A at 10:15 a.m. on . The MOR was filled in before Resident #12 received the medication. Employee A did not orally advise what the medications were. On at 10:59 a.m., the Administrator was asked to provide a policy for assistance with self-administration of medication. He stated they did not have one. A review of paperwork at the	A 052			

Agency for Health Care Administration

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A 052	Continued From page 25 facility about medications from the Department of Elder Affairs showed the following guidance was provided: Preparation of syringes for injections and giving injections is not part of medication self-administration assistance. (There was no mention of how to assist with injections/) As needed medications that require judgement, or any medication that requires judgement or discretion on the part of the unlicensed person is not part of medication self-administration assistance. Page 39 explained that as part of the process of assisting residents, staff were to read the label and prepare the medication in the resident's presence. A different packet in the facility titled, "Prevention of Medical Errors- 2019 Annual Update" stated that in 2018, Med Tech duties were expanded and included assisting with checks and bringing the to the resident, but the resident had to prepare the syringe, dial, and self-administer. This packet also addressed common medication errors. The 6 "rights" included making sure the right dose of the right medication was given to the right resident and the right time, and it was to be documented "on the MOR immediately after you observed the resident take the med." Photographic evidence obtained. During an interview on at 11:05 a.m., Employee A was asked to retrieve the medications for Resident #6 which she was observed providing at 9:49 a.m. on . She pulled two Ziploc bags containing medication	A 052			

Agency for Health Care Administration

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A 052	Continued From page 26 cards from the medication cart and confirmed these were the medications Resident #6 had taken during that medication pass. Employee A was asked how she confirmed she was giving the correct medications to the correct residents, and she explained she looked at the medications and knew who to give them to. Upon closer observation of the medication bags, a medication labeled for Resident #23 was observed (. . . , 2.5mg, once daily). She again confirmed the resident received the medications from these bags. When Resident #23's medication was pointed out, she immediately became tearful and repeatedly stated, "Oh no. I'm sorry." She was asked what the facility's policy was in this case a resident received the wrong medication, but she remained tearful and did not provide an answer. On at 11:12 a.m., the Administrator asked what had happened. Employee A remained tearful and he was advised that Resident #6 had received Resident #23's medication. He quickly reviewed the medication cards for Resident #6. Upon seeing Resident #23's medication card, he confirmed the error. He then proceeded to pull out all of Resident #23's medications from the medication cart and reviewed them individually. He was asked what the facility's policy/procedure was regarding medication errors, and he stated he would call the Primary Care Physician for Resident #6 to advise that he had received someone else's medication. He also stated that he would continue to watch Resident #6 for adverse reactions. Employee A stated in an interview on at 12:31 p.m. that she had been employed at the facility for a year and two months. She stated she	A 052			

Agency for Health Care Administration

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A 052	Continued From page 27 had received the initial six-hour training for providing assistance with self-administration of medication, and the two-hour continual training. Employee A's personnel records showed she was hired as a Med Tech. Her 6-hour Medication Technician training from a Registered Nurse was completed which included the rights and responsibilities of a Med tech, and documentation on the MOR. A 2-hour training from a Pharmacist was also taken on which included education on the Florida Statutes and how to provide assistance. Photographic evidence obtained. An interview was conducted with the Administrator on at 2:46 p.m. He was asked about the storage of the . He stated the . were not stored in the residents' rooms because they could get lost. He added, "Or they [residents] would do their everyday 8, 9, 10 times a day." He stated the . had been stored in a secured area and that the facility moved them into the lobby during COVID. When asked how he verified accuracy, he said they hadn't any issues. A review of Employee B's Med Tech personnel file revealed that training about assistance with self-administration of medications was received on . On , Employee B was observed providing assistance with self-administration of medication beginning at 9:36 a.m. for Residents #14, #15, #16, #18 and #19. During each of the observations Employee B was observed popping pills into a pill cup and initialing the MOR prior to passing the medications to the residents and	A 052	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER ARLINGTON ADULT RESIDENTIAL FACILITY INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6300 ARLINGTON EXPY. 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)
A 052	Continued From page 28 confirming they had been taken. Employee B was not orally advising the residents of their medications. On at 9:27 a.m., Resident #14 was observed checking his . The monitor read "Er 3" after several attempts. He then wrote his name and "140" in the book. Resident #14 was observed approaching the medication window on at 9:42 a.m. Employee B asked if he had taken his . He stated he had and it was 140. Employee B documented this information on the MOR. On at 9:50 a.m., Resident #2 was observed at the medication window for her medications. She handed Employee B, Med Tech, a small piece of paper with her reading of 390. He was not observed taking any measures to verify this reading. He asked her if it was "after" [breakfast] and she confirmed. Employee B explained that her should have been taken before breakfast, but he would give her the and that she needed to retake it before lunch and come . He passed her an prep and told her to wipe the area she was going to inject. After much verbal direction from Employee B, and Resident #2 requiring redirection to dial it correctly (because she put it in 31 when she only needed 25), she self-injected her . Review of the MOR showed Resident #2 was to receive 25 units daily at 8am. Photographic evidence obtained.	A 052	

Agency for Health Care Administration

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A 052	Continued From page 29 During an interview on _____ at 11:00 a.m. with the Administrator, he stated nobody receives medication administration. He was asked how the facility determined whether or not a resident could independently take medications vs. receiving assistance from staff. He replied that the 1823 health assessment form was used to determine whether the resident could self-administer medications along with the referring physician's recommendations, which would also be found on the 1823 form. When he was asked how _____ was handled, he explained that if a resident could not self-administer, "We won't take them." An interview was conducted with Employee B on _____ at 12:15 p.m. He confirmed he received Med tech training, but that he also received training specific to the facility's medication process. He was asked about the medication process for residents who received _____ and stated he gave the resident their _____, and once they "dialed it" to the dosage, he checked to be sure it was correct. He then gave them _____ their pen and watched them inject the _____. After that, he made sure the pen was "on zero" to ensure they received the right dosage. "Sometimes I have to help them take out the needles and encourage them to use the _____ pads." When he was asked how he knew the _____ dosage for each resident, since some of them were on _____, he replied that the order was on the _____ box. He stated, "I document their _____." When he was asked how he knew what each resident's _____ level was, he replied that each resident took a reading of their own _____ using their _____ in the building's lobby, documented the reading on a piece of paper, then gave the paper to him (or another Med Tech)	A 052		

Agency for Health Care Administration

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A 052	Continued From page 30 when they came for their other medications. "I make sure it is accurate because I can check their meters." Employee B was asked how he assisted Resident #2 with her today. He replied that he gave the resident her box and reminded her about the number of units to dial. She was having trouble dialing the units. He watched her try to inject the without a needle. She was having trouble putting the needle on the pen, so he "helped her out". He reminded her to use the . After she injected the , he made sure the pen was "on zero", indicating that she had received the correct dosage. He was asked whether he had received any training about injections, and he replied that he didn't, but then explained he walked residents through the process when it was time to take their . He was asked to describe the process. He stated he gave them an wipe to wipe their before checking their . He confirmed that each resident checked their before self-administering . He then gave them their and made sure they dialed it to the right dosage. When he was asked whether he did anything to the pen prior to dialing the dosage and helping Resident #2 with the needle, he replied, "no". When he was asked whether he had ever read any of the instructional inserts in the manufacturers' packaging, he said he had not read an insert in at least a year. Employee B was asked about the observation of updating the MOR prior to confirming that the resident had taken the medications. He restated the process of providing assistance with self-administration of medication. He stated that once the pill was popped into the pill cup, the	A 052			

Agency for Health Care Administration

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A 052	Continued From page 31 MOR was initiated to indicate that the medication was given. During an interview on _____ at 2:09 p.m. with the Administrator, he was asked if all residents had signed medication waivers to opt out of being orally advised of their medication names and dosages. He replied, "We haven't incorporated it into the packet but we will." He produced forms titled: "ASSISTED LIVING FACILITY AHCA Sample Format for Waiver of Assistance with Self-Administration of Medications", which had been signed by Residents #6, #8, #9, #10, #11, #12, #13, #14, #15, #16, and #18. He did not produce a form for Resident #2. A review of the signed form revealed they had not identified all of the medications intended for the resident, including names and dosages of those medications. Photographic evidence obtained. On _____ at 2:21 p.m., Resident #2 was interviewed. She was observed to be _____. She stated she checked her _____ and received _____. She was asked how she knew how much to administer, and she said "They usually do it for me." She was asked who cleaned her _____, but she did not know, she just put it in the bag. She was asked about hygiene and she just shrugged her _____. On _____ at 2:37 p.m., Employee C was observed approaching Resident #2's room door holding one of the ASSISTED LIVING FACILITY AHCA Sample Format for Waiver of Assistance with Self-Administration of Medications forms. She was asked about the form she was holding. It was an unsigned but included information for Resident #2, and was dated for _____. She	A 052			

Agency for Health Care Administration

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A 052	Continued From page 32 stated she wasn't sure what the form was, and that she was just taking it to be signed. She stated she was the housekeeper but had performed other jobs in the facility in the past. On at 3:08 p.m., the Administrator was asked about Employee C. He stated she was a housekeeper, but added, "She was a Med Tech a long time ago when she came, but that ended a while ago. She's just the Housekeeper now." He was advised that she was found with resident documentation. He replied, "I know. I handed it to her. I gave it to her to have her [Resident #2] sign it. I had it electronically on my computer." Class III	A 052		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ;	A 165		

Agency for Health Care Administration

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A 165	Continued From page 33 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be	A 165			

Agency for Health Care Administration

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A 165	Continued From page 34 reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to initiate a preliminary and 15-day adverse incident report for 1 of 23 sampled residents (Resident #17). The findings include: An interview was conducted on _____ at _____	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910300	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARLINGTON ADULT RESIDENTIAL FACILITY INC

**6300 ARLINGTON EXPY.
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 165	Continued From page 35 12:31pm with Employee A, a Medication Technician. During the interview she was asked had any resident away from the facility. She responded that Resident #17 left, and, "It's been 3 weeks and now he's not here anymore." She said it was a regular occurrence for Resident #17 to leave. On at 11:32am, the Administrator was asked to provide the 1823 health assessment and physician orders for Resident #17. He stated that the resident had been discharged, and was no longer in the facility. He was asked to provide the discharge information as well. After not receiving the records, the Administrator was asked on at 1:42pm about the information previously requested for Resident #17. He provided the 1823 and a blank medication observation record (MOR). When asked about the blank MOR, he stated the pharmacy had sent this information, adding, "it might or might not be correct." He was asked when was the last time Resident #17 was in the facility, and he responded, "I think it was . He left. He got . He doesn't want to be here. I tried to get him . He doesn't want to come . I tried to get the case manager involved. Another staff member tried to get him to come so we discharged him on ." He continued with, "He's just out there in the streets. We tried to get him . He was and released . We tried to get him and get JSO [Jacksonville Sheriff's Office] involved." He was asked again to provide a copy of the discharge notice for Resident #17. He replied, "There's no discharge notice. I want him. I want him to come but he doesn't want to. There's no elopement. We know where he is. He's out there in the streets."	A 165		

Agency for Health Care Administration

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A 165	Continued From page 36 On at 3:59pm the Administrator was asked if he had a location for Resident #17 and if he knew if he was getting his medications. He responded, "I don't have any idea. His medications are here." He added that Resident #17's Case Manager was checking the jails and hospitals. He said he was not alerted when he was released from jail. When asked to explain the facility's policy on leaving the premises, he stated, "It's in the general rules that they sign in and out." He stated that Resident #17 was not missing according to JSO, and did not think this was an elopement, because staff watched him leave the facility. He again was asked if he knew the location of Resident #17 and he responded, "No, we don't know where he is now. Several people have seen him. We discharged him on ." When it was pointed out that this statement conflicted with what was previously stated, the Administrator then stated, "We didn't get paid so we discharged him." Again, he was asked to provide a copy of the discharge notice, to which he replied, "We don't do a discharge notice. Because if he comes I'll let him in. He's not a missing person. If I call JSO they'll say he's not a missing person." He again confirmed that all of the resident's medications were at the facility. He also confirmed that he didn't have a physical location or any possible contacts for the resident. He again stated that the resident had been seen in various areas and therefore it was not an elopement so he did not need to file an adverse incident. Resident #17's records showed he was admitted into the facility on from Northeast Florida State Hospital. Review of the 1823 completed on revealed Resident #17's medical history and diagnoses included: , , , , type 2	A 165		

Agency for Health Care Administration

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A 165	Continued From page 37 and intellectual . The 1823 also stated that he required supervision with self-care (grooming) and transferring and needed assistance with self-administration of medication. Photographic evidence obtained. Review of his MOR revealed orders that included: 500mg delayed release oral tablet 1 tab by twice a day; 10mg oral tablet 1 tab by every day at bed time; 20mg oral capsule 1 cap by once a day; HCl 750mg 24 HR extended release oral tablet 1 tab by once a day; 10mg oral tablet 1 tab by twice a day; and 10mg oral tablet 1mgms by once a day. Photographic evidence obtained. The MOR for was blank (indicating Resident #17 had not received any medications during this time), and the record contained his personal identification and medical insurance cards. Review of the facility's current resident census and discharge log revealed Resident #17 was listed as an active resident with no discharge comments added. Photographic evidence obtained. Documentation provided by the facility titled, "Assisted Living Policy and Procedure Subject/Title: Elopement, Risk Prevention, and Management of Missing Residents" was reviewed. It defined elopement as, "the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way." The policy mandated that when a resident went missing, that if not found "after a period of ten minutes, the Administrator or designee calls the police and reports the resident	A 165	

Agency for Health Care Administration

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A 165	Continued From page 38 missing." Documentation provided by the facility titled, Arlington Adult Residential Facility, Inc Procedure for Responding to an Elopement was reviewed which stated that if a resident eloped as was not located, "the person in charge, preferably the Administrator, shall completely fill out the Elopement Procedure Form" which included notifying the police department, the resident's responsible party, the attending physician, and "any other regulatory agencies required by law." This document mandated that unless the resident is located within 24 hours, an adverse incident form be filled in within 1 day of the resident missing, and a full report filed after 15 days. CLASS III	A 165			