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
	AL11969137	A. BUILDING: _____ B. WING _____	07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNE ASSISTED LIVING FACILITY INC	1708 SW 11 CT FORT LAUDERDALE, FL 33312

(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 unannounced Relicensure, Limited Nursing Services (LNS) and Generator Monitoring survey was conducted on at Anne Assisted Living Facility Inc. .The facility had deficiency identied at the time of the survey..	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		

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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 review of policy and procedure, observation, interview and record review, the facility failed to maintain a written record to reflect changes in a resident's health status and medication orders, for 1 of 3 sampled residents reviewed, Resident #1. The findings included: Review of the facility policy titled Medication Administration provided by the Administrator effective documented in the Policy Statement: Medication Administration and Supervision of Self-Administration of Medication	A 025		

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A 025	Continued From page 2 ....Procedure: Prescription medications will be administered to residents ...c. Each resident's Medication Administration/Observation Record (MAR/MOR) will have the following: 1. Name 2. Diagnoses ....5. Physician's name and phone number 6. Medication name 7. Dosage 8. Route and 9. Times ....K. Staff administering medication will document information on the resident's MAR/MOR by initialing his/her name ...L. If medication is not administered, the staff will initial MAR ....The reason why the medication was not administered will be documented on the of the MAR form. Resident #1 was admitted to the facility on with diagnoses which included , -Paranoia, , , , , , and . During an initial observation and brief interview with Resident#1 on at 9:30 AM she voluntarily proceeded to reveal to the Agency for Healthcare Administration (AHCA) Surveyors by saying that she did not like the way some of her "changed" medications made her feel. She also briefly mentioned that she had experienced one (1) recent episode of agitation. On the Resident Health Assessment for Assisted Living Facilities Agency for Healthcare Administration (AHCA) Form 1823 documented that the resident had been originally ordered the following medications two (2) , , medications: 50 mg/ml take 1 ml ( ) once per month on , and 10 mg tablets three times a day ( ) on and , 20 mg take one (1) tablet orally at bedtime on ; the , was subsequently discontinued.	A 025		

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A 025	Continued From page 3 Subsequently, the following two (2) medications, had been adjusted, changed or increased on : ( ) 100 mg monthly along with, now added, , 25 mg take one (1) oral tablet two (2) times per day; AM and at Bedtime on . Lastly, the , medication had been adjusted, changed or increased on , to 50 mg take one (1) oral tablet per day AM and 100 mg at Bedtime. A brief interview was conducted on at 8:28 AM with Staff B regarding notice of any recent observed or known behavioral changes involving Resident #1. Staff B indicated that Resident #1 had an "episode" of agitation. However, she was unable to recall or provide any specific or concise instances related to this, for the resident. Record review of Resident #1's revealed that it did not contain on file any corresponding Psychiatrist notes, nor any attending Physician's notes nor letter, nor were any facility progress notes provided, during the survey, pertaining to any previous nor recent , , medication changes, adjustments or increases. During a telephone interview conducted on at 12:30 PM with Resident #1's Attending Physician, she also acknowledged that Resident #1 had an "episode" of increasing Agitation and behavioral disturbances with Fatigue, warranting an adjustment change in her medication. Moreover, she did acknowledge that a Psychiatrist note, the Attending Physician's note and any pertinent information regarding the resident's medication change needed to be	A 025		

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A 025	Continued From page 4 maintained on file in the facility, and she stated that she would be sending any additional documentation to the facility as well as Psychiatrist and Attending Physician's notes regarding the reasons as to why the resident's medications had been changed, increased or adjusted. In summary, the resident was reportedly seen previously by her physicians on the following dates: and . However, there were no notes, no Attending Physician's notes, nor any other supporting documentation provided by the facility, during the survey, as to the reason or explanation why Resident #1's medications had been adjusted, changed or increased. The Administrator further recognized and acknowledged on at 1:45 PM that Resident #1 had an "episode" of Agitation and she further indicated that there should have been documentation on file in the resident's record reflecting the changes, adjustments or increases in the resident's medications with explanations provided as to why the changes, adjustments or increases had occurred. Class III	A 025		