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
	AL11970205	A. BUILDING: _____ B. WING _____	R 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERMARK AT CORAL GABLES	363 GRANELLO AVE CORAL GABLES, FL 33146

(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 A re-visit survey was conducted at The Watermark At Coral Gables/ aka Grand Living at Coral Gables on . Deficiencies were identified at the time of the survey .	{A 000}		
{A 025} SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	{A 025}		

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{A 025}	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision and ensure the safety and physical well-being of 2 out of 19 sampled residents (#15 and #16). The residents left without staff knowing their whereabouts, and were found twelve miles away near their previous residence, unable to where they currently lived. Findings Included: Observation on at 6:32 am showed a resident waved to Staff H and stepped outside of the facility. Staff H stated his first name only, and the resident did not sign-out. The resident was	{A 025}		

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{A 025}	Continued From page 2 identified as [Resident #17]. During an interview on at 6:40 am, Staff O stated that she was helping on the 2nd floor but regularly worked on the 3rd and 4th floors. When asked if there were any Resident that eloped, she identified the Residents of as . She stated that they need to be watched because sometimes they went to the main lobby by the front doors. Observation on at 7:10 am Staff P was checking in on , Resident #17. Resident # 17 was awake and was waiting for his medication. Resident #17 had the same first name that Staff H stated earlier. During an Interview on at 710 am Staff P stated that she had just started her shift and was doing room checks. When asked if there were any residents at risk of elopement, she did not identify any residents. She stated the residents of were not , sometimes, were , and that they . During an interview on at 8:12 am, Staff P stated that the residents in had not eloped. Observation on at 8:14 am showed that on the 4th floor, # was occupied by Residents #15 and #16. During an interview on at 8:15 am, the Director of Nursing stated that there was no resident at risk of elopement. A review of Residents # 15 and #16's progress notes showed that they left the facility on	{A 025}		

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{A 025}	Continued From page 3 During an interview on with Staff K stated that residents need to check in and out of the front if they are leaving. When asked what was the procedure if they don't check in or out, she said that she would manually check them in or out and send an email notifying management. Observation on at 11:05 am showed Resident #17 again waved at Staff K and stepped outside the facility. Staff K did not notice Resident # 17. A review of the computer sign-in and sign-out showed that Resident #17 had signed-out at 11:05 am, and had not signed out when leaving the facility at 7:10 am. A review of the facility elopement policy showed that if a "resident does not sign-out of the facility, it is therefore understood by the community that the resident left the community without following policy and procedures." The policy further stated that the "Definition of Elopement is when a resident leaves the community without following the Community Policy and Procedures." A review of the sign-in and sign-out logs for showed that Resident # 15 and #16 did not sign-in or sign-out. A review of Residents #15 and #16's health assessments dated showed that they were both "AAOX1" and were not elopement risk. According to the National Institutes of Health, "There are four alert and orientation (AAO) levels. AAO X1 know their names and significant others. AAO X2 know their names and significant others	{A 025}		

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{A 025}	Continued From page 4 and understand where they are. AAO X3 know their names and significant others, understand where they are, and know the day of week and seasons, AAO X4 know their names and significant others, understand where they are, know the day of week and seasons, and understand their situation." A review of the elopement policy showed that some risk factors for elopement were "diagnoses of , , , or , , history of or prior elopement, new admissions or changes in environment, expressed desire to "go home", restlessness, pacing, or exit seeking behavior." During an interview on at 12:25 pm the Administrator stated that Residents #15 and #16 left the facility on and were brought by their chauffeur after they received notification from the daughter that they were 12 miles away at their previous residence. According to the Administrator they were not assessed as on and had just moved in, when asked if she believed they were an elopement risk. She recalled speaking to the daughter about the memory care services after the incident. When asked if she considered the Residents # 15 and #16 an elopement risk, she stated no. When asked why staff interviewed considered them problematic and . She said that they refused care and medication and were 'difficult in general.' Uncorrected Class II	{A 025}		
{A 055} SS=D	59A-36.008(6) FAC Medication - Storage and Disposal	{A 055}		

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{A 055}	Continued From page 5 (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 6 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 7 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, interview and Record Review, the facility failed to ensure that medication were securely stored. The facility failed to ensure that the over-the-counter medication of one out of 17 sampled residents was locked in the facility's central storage (Resident #7). Findings: On at 8:06 AM, observation revealed that Resident 7 received assistance with medication self-administered by Staff D. On at 8:06 AM, the following Over the Counter medication were observed unlocked in Resident 7's bathroom: , , cream, , , , , , , and . On at 8:06 AM, Resident 7 stated that she had Diverticulosis. Resident 7 stated that she needed to have access to certain medication as soon as she had concerns with the diverticulosis. According to the National Library of Medicine, "Diverticula are small pouches, or , that bulge outward through weak spots in your . They mostly form in the lower part of the .	{A 055}		

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{A 055}	Continued From page 8 Diverticulosis is a condition in which you have these pouches. Most people who have diverticulosis do not have symptoms or problems. But sometimes the pouches can cause symptoms or become ." . On at 8:06 AM, Resident 7 stated that she'd had the supply of over-the-counter medication since she came to the facility. Resident 7 stated that she was competent and able to manage her own medication. A review of Resident 7's health assessment dated , revealed that she required assistance with self-administration of medication. On at 8:25 AM, the Administrator stated that a message was sent out to the residents and their family members that there should be no over-the-counter medication in the rooms. On at 8:30 AM The Director of Nursing, regarding the medication observed in the resident's room, stated that she would get the medication and obtain an order for them from the doctor. Class III	{A 055}		
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	A 152		

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A 152	Continued From page 9 section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, 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 and interview the facility failed to ensure that it maintained a safe living environment free from hazards for two out of 19 sampled residents (Resident #18 and Resident	A 152		

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A	Continued From page 10 #19). Findings include: An observation on at 7:32AM revealed that there were unsecured cleaning supplies such as glass cleaner, bleach, spot remover and a scouring powder located in the cabinet under Resident #19's kitchen sink. An observation on at 7:47AM revealed that a mattress had been placed lengthwise against the living room wall, standing directly over the end of Resident #18's couch. During an interview on at 7:47AM, Staff P (Caregiver) stated that Resident #18 had her mattress changed recently and that the old mattress would be picked up. Staff P further stated that the family would be responsible for removing the mattress. During an interview on at 1:05PM, when informed about the mattress in Resident #18's room and the risk it posed of falling on the resident, the Administrator stated that the resident's son was still in Japan. Uncorrected Class III	A 152		
A 058 SS=F	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations,	A 058		

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A 058	Continued From page 11 including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III	A 058		

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A 058	Continued From page 12 deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on Observation, Interview and record review, the facility failed to ensure that a medication deficiency was corrected. The facility is required to retain a registered nurse to to develop and implent a corrective action plan and deliver onsite consutation within 14 days. The facility must maintain the consultant services until they are no longer rquired. Findings: Facility record review revealed that on ,the facility was cited for a deficiency regarding medication storage and disposal. On at 8:06 AM, over the counter medications were observed in an unlocked cabinet located in Resident 7's bathroom.	A 058		

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A 058	Continued From page 13 On at 8:06AM, the following Over the Counter medication were observed in Resident 7's bathroom: , , cream, , , , , , , , , and . Class III	A 058		

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{A 000}	Initial Comments A re-visit survey was conducted at The Watermark At Coral Gables/ aka Grand Living at Coral Gables on . Deficiencies were identified at the time of the survey .	{A 000}		
{A 025} SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	{A 025}		

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	AL11970205	A. BUILDING: _____ B. WING _____	R 12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{A 025}	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision and ensure the safety and physical well-being of 2 out of 19 sampled residents (#15 and #16). The residents left without staff knowing their whereabouts, and were found twelve miles away near their previous residence, unable to where they currently lived. Findings Included: Observation on at 6:32 am showed a resident waved to Staff H and stepped outside of the facility. Staff H stated his first name only, and the resident did not sign-out. The resident was	{A 025}		

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{A 025}	Continued From page 2 identified as [Resident #17]. During an interview on at 6:40 am, Staff O stated that she was helping on the 2nd floor but regularly worked on the 3rd and 4th floors. When asked if there were any Resident that eloped, she identified the Residents of as . She stated that they need to be watched because sometimes they went to the main lobby by the front doors. Observation on at 7:10 am Staff P was checking in on , Resident #17. Resident # 17 was awake and was waiting for his medication. Resident #17 had the same first name that Staff H stated earlier. During an Interview on at 710 am Staff P stated that she had just started her shift and was doing room checks. When asked if there were any residents at risk of elopement, she did not identify any residents. She stated the residents of were not , sometimes, were , and that they . During an interview on at 8:12 am, Staff P stated that the residents in had not eloped. Observation on at 8:14 am showed that on the 4th floor, # was occupied by Residents #15 and #16. During an interview on at 8:15 am, the Director of Nursing stated that there was no resident at risk of elopement. A review of Residents # 15 and #16's progress notes showed that they left the facility on	{A 025}		

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{A 025}	Continued From page 3 During an interview on with Staff K stated that residents need to check in and out of the front if they are leaving. When asked what was the procedure if they don't check in or out, she said that she would manually check them in or out and send an email notifying management. Observation on at 11:05 am showed Resident #17 again waved at Staff K and stepped outside the facility. Staff K did not notice Resident # 17. A review of the computer sign-in and sign-out showed that Resident #17 had signed-out at 11:05 am, and had not signed out when leaving the facility at 7:10 am. A review of the facility elopement policy showed that if a "resident does not sign-out of the facility, it is therefore understood by the community that the resident left the community without following policy and procedures." The policy further stated that the "Definition of Elopement is when a resident leaves the community without following the Community Policy and Procedures." A review of the sign-in and sign-out logs for showed that Resident # 15 and #16 did not sign-in or sign-out. A review of Residents #15 and #16's health assessments dated showed that they were both "AAOX1" and were not elopement risk. According to the National Institutes of Health, "There are four alert and orientation (AAO) levels. AAO X1 know their names and significant others. AAO X2 know their names and significant others	{A 025}		

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{A 025}	Continued From page 4 and understand where they are. AAO X3 know their names and significant others, understand where they are, and know the day of week and seasons, AAO X4 know their names and significant others, understand where they are, know the day of week and seasons, and understand their situation." A review of the elopement policy showed that some risk factors for elopement were "diagnoses of , , , or , , history of or prior elopement, new admissions or changes in environment, expressed desire to "go home", restlessness, pacing, or exit seeking behavior." During an interview on at 12:25 pm the Administrator stated that Residents #15 and #16 left the facility on and were brought by their chauffeur after they received notification from the daughter that they were 12 miles away at their previous residence. According to the Administrator they were not assessed as on and had just moved in, when asked if she believed they were an elopement risk. She recalled speaking to the daughter about the memory care services after the incident. When asked if she considered the Residents # 15 and #16 an elopement risk, she stated no. When asked why staff interviewed considered them problematic and . She said that they refused care and medication and were 'difficult in general.' Uncorrected Class II	{A 025}		
{A 055} SS=D	59A-36.008(6) FAC Medication - Storage and Disposal	{A 055}		

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{A 055}	Continued From page 5 (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 6 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 7 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, interview and Record Review, the facility failed to ensure that medication were securely stored. The facility failed to ensure that the over-the-counter medication of one out of 17 sampled residents was locked in the facility's central storage (Resident #7). Findings: On at 8:06 AM, observation revealed that Resident 7 received assistance with medication self-administered by Staff D. On at 8:06 AM, the following Over the Counter medication were observed unlocked in Resident 7's bathroom: , , cream, , , , , , , and . On at 8:06 AM, Resident 7 stated that she had Diverticulosis. Resident 7 stated that she needed to have access to certain medication as soon as she had concerns with the diverticulosis. According to the National Library of Medicine, "Diverticula are small pouches, or , that bulge outward through weak spots in your . They mostly form in the lower part of the .	{A 055}		

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{A 055}	Continued From page 8 Diverticulosis is a condition in which you have these pouches. Most people who have diverticulosis do not have symptoms or problems. But sometimes the pouches can cause symptoms or become ." . On at 8:06 AM, Resident 7 stated that she'd had the supply of over-the-counter medication since she came to the facility. Resident 7 stated that she was competent and able to manage her own medication. A review of Resident 7's health assessment dated , revealed that she required assistance with self-administration of medication. On at 8:25 AM, the Administrator stated that a message was sent out to the residents and their family members that there should be no over-the-counter medication in the rooms. On at 8:30 AM The Director of Nursing, regarding the medication observed in the resident's room, stated that she would get the medication and obtain an order for them from the doctor. Class III	{A 055}		
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	A 152		

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A 152	Continued From page 9 section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, 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 and interview the facility failed to ensure that it maintained a safe living environment free from hazards for two out of 19 sampled residents (Resident #18 and Resident	A 152		

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A	Continued From page 10 #19). Findings include: An observation on at 7:32AM revealed that there were unsecured cleaning supplies such as glass cleaner, bleach, spot remover and a scouring powder located in the cabinet under Resident #19's kitchen sink. An observation on at 7:47AM revealed that a mattress had been placed lengthwise against the living room wall, standing directly over the end of Resident #18's couch. During an interview on at 7:47AM, Staff P (Caregiver) stated that Resident #18 had her mattress changed recently and that the old mattress would be picked up. Staff P further stated that the family would be responsible for removing the mattress. During an interview on at 1:05PM, when informed about the mattress in Resident #18's room and the risk it posed of falling on the resident, the Administrator stated that the resident's son was still in Japan. Uncorrected Class III	A 152		
A 058 SS=F	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations,	A 058		

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A 058	Continued From page 11 including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III	A 058		

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A 058	Continued From page 12 deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on Observation, Interview and record review, the facility failed to ensure that a medication deficiency was corrected. The facility is required to retain a registered nurse to to develop and implent a corrective action plan and deliver onsite consutation within 14 days. The facility must maintain the consultant services until they are no longer rquired. Findings: Facility record review revealed that on ,the facility was cited for a deficiency regarding medication storage and disposal. On at 8:06 AM, over the counter medications were observed in an unlocked cabinet located in Resident 7's bathroom.	A 058		

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A 058	Continued From page 13 On at 8:06AM, the following Over the Counter medication were observed in Resident 7's bathroom: , , cream, , , , , , , , , and . Class III	A 058		

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{A 000}	Initial Comments A re-visit survey was conducted at The Watermark At Coral Gables/ aka Grand Living at Coral Gables on . Deficiencies were identified at the time of the survey .	{A 000}		
{A 025} SS=H	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	{A 025}		

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{A 025}	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision and ensure the safety and physical well-being of 2 out of 19 sampled residents (#15 and #16). The residents left without staff knowing their whereabouts, and were found twelve miles away near their previous residence, unable to where they currently lived. Findings Included: Observation on at 6:32 am showed a resident waved to Staff H and stepped outside of the facility. Staff H stated his first name only, and the resident did not sign-out. The resident was	{A 025}		

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{A 025}	Continued From page 2 identified as [Resident #17]. During an interview on at 6:40 am, Staff O stated that she was helping on the 2nd floor but regularly worked on the 3rd and 4th floors. When asked if there were any Resident that eloped, she identified the Residents of as . She stated that they need to be watched because sometimes they went to the main lobby by the front doors. Observation on at 7:10 am Staff P was checking in on , Resident #17. Resident # 17 was awake and was waiting for his medication. Resident #17 had the same first name that Staff H stated earlier. During an Interview on at 710 am Staff P stated that she had just started her shift and was doing room checks. When asked if there were any residents at risk of elopement, she did not identify any residents. She stated the residents of were not , sometimes, were , and that they . During an interview on at 8:12 am, Staff P stated that the residents in had not eloped. Observation on at 8:14 am showed that on the 4th floor, # was occupied by Residents #15 and #16. During an interview on at 8:15 am, the Director of Nursing stated that there was no resident at risk of elopement. A review of Residents # 15 and #16's progress notes showed that they left the facility on	{A 025}		

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{A 025}	Continued From page 3 During an interview on with Staff K stated that residents need to check in and out of the front if they are leaving. When asked what was the procedure if they don't check in or out, she said that she would manually check them in or out and send an email notifying management. Observation on at 11:05 am showed Resident #17 again waved at Staff K and stepped outside the facility. Staff K did not notice Resident # 17. A review of the computer sign-in and sign-out showed that Resident #17 had signed-out at 11:05 am, and had not signed out when leaving the facility at 7:10 am. A review of the facility elopement policy showed that if a "resident does not sign-out of the facility, it is therefore understood by the community that the resident left the community without following policy and procedures." The policy further stated that the "Definition of Elopement is when a resident leaves the community without following the Community Policy and Procedures." A review of the sign-in and sign-out logs for showed that Resident # 15 and #16 did not sign-in or sign-out. A review of Residents #15 and #16's health assessments dated showed that they were both "AAOX1" and were not elopement risk. According to the National Institutes of Health, "There are four alert and orientation (AAO) levels. AAO X1 know their names and significant others. AAO X2 know their names and significant others	{A 025}		

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{A 025}	Continued From page 4 and understand where they are. AAO X3 know their names and significant others, understand where they are, and know the day of week and seasons, AAO X4 know their names and significant others, understand where they are, know the day of week and seasons, and understand their situation." A review of the elopement policy showed that some risk factors for elopement were "diagnoses of , , , or , , history of or prior elopement, new admissions or changes in environment, expressed desire to "go home", restlessness, pacing, or exit seeking behavior." During an interview on at 12:25 pm the Administrator stated that Residents #15 and #16 left the facility on and were brought by their chauffeur after they received notification from the daughter that they were 12 miles away at their previous residence. According to the Administrator they were not assessed as on and had just moved in, when asked if she believed they were an elopement risk. She recalled speaking to the daughter about the memory care services after the incident. When asked if she considered the Residents # 15 and #16 an elopement risk, she stated no. When asked why staff interviewed considered them problematic and . She said that they refused care and medication and were 'difficult in general.' Uncorrected Class II	{A 025}		
{A 055} SS=D	59A-36.008(6) FAC Medication - Storage and Disposal	{A 055}		

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{A 055}	Continued From page 5 (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 6 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 7 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, interview and Record Review, the facility failed to ensure that medication were securely stored. The facility failed to ensure that the over-the-counter medication of one out of 17 sampled residents was locked in the facility's central storage (Resident #7). Findings: On at 8:06 AM, observation revealed that Resident 7 received assistance with medication self-administered by Staff D. On at 8:06 AM, the following Over the Counter medication were observed unlocked in Resident 7's bathroom: , , cream, , , , , , , and . On at 8:06 AM, Resident 7 stated that she had Diverticulosis. Resident 7 stated that she needed to have access to certain medication as soon as she had concerns with the diverticulosis. According to the National Library of Medicine, "Diverticula are small pouches, or , that bulge outward through weak spots in your . They mostly form in the lower part of the .	{A 055}		

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{A 055}	Continued From page 8 Diverticulosis is a condition in which you have these pouches. Most people who have diverticulosis do not have symptoms or problems. But sometimes the pouches can cause symptoms or become ." . On at 8:06 AM, Resident 7 stated that she'd had the supply of over-the-counter medication since she came to the facility. Resident 7 stated that she was competent and able to manage her own medication. A review of Resident 7's health assessment dated , revealed that she required assistance with self-administration of medication. On at 8:25 AM, the Administrator stated that a message was sent out to the residents and their family members that there should be no over-the-counter medication in the rooms. On at 8:30 AM The Director of Nursing, regarding the medication observed in the resident's room, stated that she would get the medication and obtain an order for them from the doctor. Class III	{A 055}		
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	A 152		

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A 152	Continued From page 9 section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, 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 and interview the facility failed to ensure that it maintained a safe living environment free from hazards for two out of 19 sampled residents (Resident #18 and Resident	A 152		

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A	Continued From page 10 #19). Findings include: An observation on at 7:32AM revealed that there were unsecured cleaning supplies such as glass cleaner, bleach, spot remover and a scouring powder located in the cabinet under Resident #19's kitchen sink. An observation on at 7:47AM revealed that a mattress had been placed lengthwise against the living room wall, standing directly over the end of Resident #18's couch. During an interview on at 7:47AM, Staff P (Caregiver) stated that Resident #18 had her mattress changed recently and that the old mattress would be picked up. Staff P further stated that the family would be responsible for removing the mattress. During an interview on at 1:05PM, when informed about the mattress in Resident #18's room and the risk it posed of falling on the resident, the Administrator stated that the resident's son was still in Japan. Uncorrected Class III	A 152		
A 058 SS=F	429.42( ) FS; 58A-5.033(3)(a) FAC Pharmacy & Dietary; Uncorrected Deficiencies 429.42 Pharmacy and dietary services.- (1) Any assisted living facility in which the agency has documented a class I or class II deficiency or uncorrected class III deficiencies regarding medicinal drugs or over-the-counter preparations,	A 058		

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A 058	Continued From page 11 including their storage, use, delivery, or administration, or dietary services, or both, during a biennial survey or a monitoring visit or an investigation in response to a complaint, shall, in addition to or as an alternative to any penalties imposed under s. 429.19, be required to employ the consultant services of a licensed pharmacist, a licensed registered nurse, or a registered or licensed dietitian, as applicable. The consultant shall, at a minimum, provide onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required. (2) A corrective action plan for deficiencies related to assistance with the self-administration of medication or the administration of medication must be developed and implemented by the facility within 48 hours after notification of such deficiency, or sooner if the deficiency is determined by the agency to be life-threatening. 58A-5.033(3) (3) EMPLOYMENT OF A CONSULTANT. (a) Medication Deficiencies. 1. If a class I, class II, or uncorrected class III deficiency directly relating to facility medication practices as established in Rule 58A-5.0185, F.A.C., is documented by the agency pursuant to an inspection of the facility, the agency must notify the facility in writing that the facility must employ or contract the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or registered nurse as determined by the agency. 2. After developing and implementing a corrective action plan in compliance with Section 429.42(2), F.S., the initial on-site consultant visit must take place within 7 working days of the notice of the class I or II deficiency and within 14 working days of the notice of an uncorrected class III	A 058		

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A 058	Continued From page 12 deficiency. The facility must have available for review by the agency a copy of the license of the consultant pharmacist or registered nurse and the consultant's signed and dated review of the corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit. 3. The facility must provide the agency with, at a minimum, quarterly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required. The agency must provide the facility with written notification of such determination. This Statute or Rule is not met as evidenced by: Based on Observation, Interview and record review, the facility failed to ensure that a medication deficiency was corrected. The facility is required to retain a registered nurse to to develop and implent a corrective action plan and deliver onsite consutation within 14 days. The facility must maintain the consultant services until they are no longer rquired. Findings: Facility record review revealed that on ,the facility was cited for a deficiency regarding medication storage and disposal. On at 8:06 AM, over the counter medications were observed in an unlocked cabinet located in Resident 7's bathroom.	A 058		

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A 058	Continued From page 13 On at 8:06AM, the following Over the Counter medication were observed in Resident 7's bathroom: , , cream, , , , , , , , , and . Class III	A 058		