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 _____	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING 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 165 SS=D	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. ; 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	A 165		

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A 165	Continued From page 1 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 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	A 165		

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A 165	Continued From page 2 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 ensure that a preliminary adverse incident report was reported to the Agency of Health Care Administration (AHCA) within one day, for one out of 37 sampled residents (Resident # 2). Findings include: A review of a report from another state's agency showed that a medication error had occurred at the facility, and a resident had been given medication that belonged to another resident. A review of the Agency Intake Report System (AIRS) showed that there was no adverse incident report filed by the facility for a medication error. On at 11:40 AM, Staff F (Director of Health and Wellness) denied that a medication error had occurred at the facility, then, when asked again, she stated, "I think you are talking about Resident # 2, it happened in ." Then stated that the nurse had made a mistake and gave Resident # 2 a medication that belonged to another resident with the same last	A 165		

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A 165	Continued From page 3 name's initial, and that she would get the report. On at 12:31 PM the Administrator stated that they had not filed an incident report with the state because they could not find what to mark on the report. Class III	A 165		
A 000	Initial Comments A complaint investigation (2026009273) survey was conducted at The Watermark at Coral Gables/ also known as (aka) Grand Living at Coral Gables on - . Deficiencies were identified at the time of the survey. Class 1 deficiencies were found at tag A0030 and A0076. A Class 1 deficiency is a deficiency that the Agency determines presents a situation in which immediate corrective action is necessary because the facility's non-compliance has caused, or is likely to cause, serious injury, harm, , or to a resident receiving care in a facility. The Class 1 non-compliance began on . The facility Administrator was notified of the Class 1 non-compliance on . The census at the start of the survey was 54 residents. The facility failed to ensure that Resident #1's Do	A 000		

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A 000	Continued From page 4 Not Order ( ) accompanied the resident and was communicated to Emergency Medical Services ( ) at the time of the emergency. Staff Interviews revealed that Staff B (Registered Nurse/ Supervisor) could not recall whether the documentation was provided to and did not verbally inform of the resident's status. Additionally, Staff E (Concierge) stated that the paperwork was not provided because their printer was not functioning and staff believed the documentation was being supplied from the fourth-floor nursing station. As a result, and hospital personnel did not have the residents' documentation available and initiated resuscitative measures. The following is a description of the deficiencies found at the time of the visit: A0036, A0056, A0077, A0078, A0152, A0165	A 000		
A 030 SS=L	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able	A 030		

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A 030	Continued From page 5 to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules	A 030		

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A 030	Continued From page 6 or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at	A 030		

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A 030	Continued From page 7 any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless,	A 030		

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A 030	Continued From page 8 for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and	A 030		

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the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the

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A 030	Continued From page 10 resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident's rights were upheld for one out of 37 sampled residents (Resident #1) who had an active ( ) in place. Staff failed to provide the required documentation to emergency medical services ( ), which resulted in and the hospital initiating life-saving measures on Resident #1. Findings Included: A review of Resident 1's records revealed that the resident on and had a ( ) on file. Also, Resident #1 was not feeling well the previous day on and noted that Resident #1 was experiencing A review of Resident 1's health assessment dated showed diagnoses of , and . Noted in the physical or limitation section was that Resident #1 used a walker, wheelchair, and cane. Resident #1 needed assistance with all Activities of Daily Living except eating he was independent. A review of the hospital records dated revealed that, Resident #1 arrived there at 7:48 AM, via Fire Rescue while intubated. The record documented that ( ) had been initiated in the ambulance and	A 030		

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the resident had gone into , (without a hearbeat) and received "2 doses of , , and 2 grams of , ." A review of data from the National Library of health showed that , was an and , , is used to treat life threatening low , .

Further review of the hospital records revealed that while in the Emergency Department, Resident #1 continued to receive resuscitative efforts, including , multiple doses of , , , and (Bicard). The records showed that after 45 minutes of resuscitative efforts in the Emergency Department, in addition to the provided pre-hospital, the attending physician determined that any further efforts would be medically futile.

Additional review of the hospital record showed Resident #1 was pronounced at 8:34 AM.

During an interview via telephone on at 1:39 PM with Staff C (Medication Technician) stated that he worked from 7:00 PM to 7:00 AM. The staff further stated that near the end of his shift, he was notified by another staff member that a resident was unstable. Staff C stated that he immediately responded to the resident's room, called the resident's name, and performed a rub to assess responsiveness. He further stated that he used the radio to contact the nurse [Staff B] and continued to assess the resident for responsiveness until the nurse arrived. When the nurse arrived Staff C stated that he then proceeded to gather documentation for , including the resident's sheet and the medication list. When asked whether he had performed on the resident, Staff C stated,

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A 030	Continued From page 12 "I'm sorry can you call me ? Just give me a moment. My is in an emotional state right now. I'm just trying to see ..." After multiple attempts to ask if Staff C had performed on Resident #1, no further response was obtained at that time. During an interview on at 10:06 AM with Staff B (Registered Nurse/ Supervisor) worked from 7:00 AM -7:00 PM on . Staff B stated that he responded to the resident after being notified by Staff C that the resident was having breathing difficulties. Staff B arrived at the resident room and stated that Resident #1 was difficult to arouse, unresponsive to verbal stimuli, and experiencing breathing difficulties. After noting a low level of '88 stat', he called 911 and remained on the phone with the dispatcher until arrived. Staff B confirmed that he was aware that the resident had a on file. However, he stated that he did not verbally inform of the resident's status. Although he believed received a copy of the documentation, he could not identify who provided the paperwork to . Staff B further stated that he did not observe any life-saving measures being performed by and denied that facility staff performed During an interview on at 12:06 PM Staff B stated that the resident had not been transferred to the hospital the previous day on despite not feeling well because had been prescribed and staff were waiting for the medication order to be processed. Staff B was asked why the resident had not received the prescribed after the order was issued. Staff B stated that the medication had been ordered by the resident's nurse	A 030		

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practitioner through the resident's PCP and that staff were awaiting delivery from the pharmacy. Staff B stated that medications are typically received on the same day; however, there was no specific delivery timeframe. Staff B further stated that while awaiting the medication, the resident's condition declined and the resident was subsequently transferred to the hospital.

Interviewed on at 10:45 AM Staff D (Concierge) stated that she worked from 7:00 AM to 3:30 PM and that she was still in training at the time of the incident. Staff D stated that she contacted the nurse when arrived, the nurse informed her of the resident's floor location. Staff D further stated that, as part of the facility's normal practice, was typically provided with the resident's sheet and medication list. Staff D stated that the resident's was also generally included with the documents provided to . However, Staff D was unable to confirm whether the documentation was provided to during this specific incident or identify who provided the documentation.

During an interview on at 10:51 AM Staff E (Concierge) worked from 7:00 AM to 3:30 PM stated that she was beginning her shift when she was notified by nursing staff that fire rescue was en route to the facility for Resident #1. Staff E stated that staff directed to the resident's location and that the nurse met upon arrival. Staff E stated that the facility's usual practice was provided to with the resident's sheet, medication list, and when time permitted. However, she stated that arrived quickly, and the documents were not ready in time to be provided. Staff E further stated that on the day of the incident, the printer was not functioning properly, which prevented staff from printing the

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A 030	Continued From page 14 required documentation. She stated that as a result, the sheet, medication list, and were not provided to by staff, and she believed the documentation may have been provided from nursing station which is located on the fourth floor. According to the Department of Health, "A ( ) is a form or patient identification device developed by the Florida Department of Health to identify people who do not wish to be in the event of , , or ." The form authorizes withholding measures, including , , , and in the event of or , , . A review of facility records revealed that 31 out of 57 residents had active on file, reflecting their documented preferences not to be in the event of , , . Interviewed on at 12:21 PM the Director of Health & Wellness stated that the facility's process if the nurse was not present, the concierge/ front desk staff would provide the documentation. A review of the facility's orders and Advance Director Medical Emergency policy showed, "Emergency Response: 1. Determine / status a. Immediately verify if the resident has a valid on file. b. Contact the following, in order to confirm the resident's current status: i. Nurse on Duty, Med Tech or Health &	A 030		

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A 030	Continued From page 15 Wellness (H&W) team- verify in the resident's electronic medical record (Eldermark) or binder. ii. If the H&W team is unavailable, contact the Concierge/Receptionist to access the resident file or binder. iii. If still unclear escalate immediately to the Executive Director for direction. c. Once confirmed, proceed according to the presence or absence of a valid . 2. If valid present: a. Do not perform . b. Call 911 and notify . c. Provide with resident's sheet, medication list, and (concierge, if not H&W Team member, pull from the binder located at the Concierge / Front Desk)" A review of Staff B's personnel records showed a hire date of and current in service training dated . A review of Staff C's personnel records showed a hire date of and current training dated . A review of Staff D's personnel records showed a hire date of and current training dated . A review of Staff E's personnel records showed a hire date of and current training dated . Class I	A 030		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES	A 036		

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A 036	Continued From page 16 (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 mucuous 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 observation, interview, and record review, the facility failed to ensure staff performed proper hygiene and followed standard precautions before and after providing personal care services. Staff did not follow the facility's control policies and procedures for three of 37 sample residents (Residents #4, #17, and #18). Findings Included: Observed during the facility tour on at	A 036		

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A 036	Continued From page 17 7:19 a.m. Staff H (Medication Technician) was working on the second-floor memory unit. Staff H entered , adjusted Resident #17's pillow. Staff H then entered to assist Resident #18 by raising the of the bed and adjusting the resident's . Staff H did not wash her before or after providing this care. At 7:46 a.m. on , observed Staff B, Registered Nurse (RN) Supervisor, assisting Resident #4 with self-administration of medication by punching a pill from a pack into a disposable cup. Resident #4 dropped one pill onto the floor. Staff B picked up the pill with his bare and gave it to the resident. Resident #4 swallowed the pill. Record review of Staff B, Registered Nurse (RN) Supervisor showed control and Universal Precautions 2 hours training dated . Record review of staff H (medication Technician) showed control training 2 hours credit dated . A review of the facility's Control Policy and Procedure showed the following general procedures: . washing is the most important method of control. .. must be washed between direct contact with any resident, after cleaning tasks, or any task that presents an opportunity for . must always be washed before and after handling medications (Medication Guide, 2012). During the preliminary exit interview on , at 12:28 p.m., Staff F (Director of	A 036		

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A 036	Continued From page 18 Health and Wellness) stated, "Staff did not wash her ?" Class III	A 036		
A 056 SS=G	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the	A 056		

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A 056	Continued From page 19 medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:	A 056		

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A 056	Continued From page 20 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to follow physician orders for one out of 37 sampled residents (Resident # 2). Resident # 2 was administered a medication that belonged to Resident # 22, this medication could have caused adverse reactions. Findings included: A review of a report from another state's agency showed that a medication error had occurred at the facility on , a resident had been given medication that belonged to another resident, no name of the resident was provided. A review of facility's records showed that Staff C (Licensed Practical Nurse) had administered , 7.5 mg instead of the prescribed , 0.25 mg to Resident # 2. Staff C has a Licensed Practical Nurse that expires on . According to Mayo Clinic , is used to treat (trouble sleeping). It belongs to the group of medicines called .	A 056		

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A 056	Continued From page 21 ( ) depressants, which slows down the nervous system. Elderly patients are more sensitive to the effects of this medicine (eg, , , and falling) than younger adults. A review of residents' records showed that Resident # 2 had a health assessment completed on and had been diagnosed with , , , , , D deficiency, , , , , , , , , and . Required assistance with self-administration of medications. The resident was on precautions. On at 11:40 AM, Staff F (Director of Health and Wellness) denied that a medication error had occurred at the facility, then, when asked again, she stated, "I think you are talking about Resident # 2, it happened in ." Then stated that Staff C had made a mistake and gave Resident # 2 a medication that belonged to another resident with the same last name's initial, and that she would get the report. She stated that the medication error had happened because the resident had the same initials as another resident, the nurse did not look at the full name and got the medication from the other resident, instead of 0.5 mg she had been given , 10 mg. The error was discovered by Staff C after the medication had already been administered, during routine shift-controlled medication count verification. According to facility the staff were educated to	A 056		

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A 056	Continued From page 22 reinforce adherence to the five rights of medication administration. Nursing staff were trained in medication administration and medication error prevention. Nursing staff were trained in medication administration and medication error prevention. On at 1:00 PM copy of the staff training was requested and the facility failed to provide them. Class II	A 056		
A 076 SS=J	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and,	A 076		

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A 076	Continued From page 23 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005. (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , , , staff trained in , , ( ) or a health care provider present in the facility, may withhold , , (, , , and). (b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact	A 076		

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A 076	Continued From page 24	A 076		

hospice staff. The hospice procedures take precedence over those of the assisted living facility.

This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure that it followed and adhered to its ( ) policies and procedures. The facility failed to ensure that an executed form was readily available and accessible to medical staff during an emergency response and failed to ensure that it honored a properly executed order for one out of 37 sampled residents (Resident #1).

Findings include:

A review of Resident #1's record revealed that the resident had a properly executed in his file dated . According to the Florida Department of Health, "A ( ) is a one-page, easily-identifiable form developed by the Florida Department of Health, is only intended to identify a patient whose health care provider has directed paramedics and emergency medical technicians (EMT) not to the patient in the event of , , or ."

A review of the internal incident report revealed that on , staff responded to Resident #1's room due to a report of difficulty breathing. The resident was found to be , to verbal commands and Emergency Medical Services ( ) were called. arrived and transported the resident to a hospital. The Hospital later notified the facility that Resident #1 expired at 8:45 AM.

A review of Resident #1's hospital record dated

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A 076	Continued From page 25 revealed that Resident #1 presented to the Hospital Emergency Department (ED), where "[Resident 1] went to , got epi [, ,] and had return of spontaneous regulation but then he did not have a , when he arrived. While in the Emergency Room (ER) the patient was with [, ,] and he was given multiple doses of , , as well as bicarb." Further review revealed that " started in the truck". During an interview on with Staff B (Registered Nurse), he was asked to recall the events that led to Resident #1's transfer to the hospital via . Staff B stated that when he arrived for his shift, Resident #1 had trouble breathing and responding to stimuli. After assessing the resident, Staff B called 911. When asked if he was aware that Resident #1 had a , he stated "from before I knew it and it was in our system as well." When asked if he informed that Resident #1 had a , he stated that he did not tell them verbally, but he thought that they received a copy. He further stated that he could not recall who provided the with the paper. During an interview on at 10:49 AM with Staff D (Concierge) she was asked what the front desk's responsibilities were when is called to the facility, to which she stated that they would give a copy of the resident's medication list and sheet. When asked where would get a resident's from, she answered, "Most likely they would get that from the nurse's station." During an interview on at 10:51 AM with Staff E (Concierge), when asked to recall the	A 076		

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A 076	Continued From page 26 events that led to Resident #1's transfer to the hospital via , she stated that when she arrived for her shift, Staff B called the front desk to inform her and Staff D that fire rescue was called for Resident #1. She stated that once fire rescue arrived, she advised them on how to get upstairs and let Staff B know that they had arrived. When asked what the front desk's responsibilities were when is called to the facility, she stated that they would print a copy of the sheet, the medication list and a copy of the ; she stated that sometimes if they do not have it ready, the nurses would give it to them [ ] upstairs. She further stated, "That day we did not give it to them because the printer was acting up, so the documentation was given to them upstairs". During an interview on at 1:39 PM with Staff C (Medication-Technician) when asked to recall the events that led to Resident #1's transfer to the hospital via , he stated that he was informed that Resident #1 was unstable. He then contacted Staff B and assessed the resident. Staff C confirmed that once Staff B arrived, Staff B took over the resident's care. After multiple attempts to determine whether Staff C performed on Resident #1, Staff C was unable to confirm or deny doing so. A review of the " ( ) Orders and Advance Directives Medical Emergency Internal Procedures" revealed that the following procedure should have been followed: "Health & Wellness Team/Direct Care Staff: - Confirm status before giving emergency care. Provide unless a valid is present.	A 076		

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A 076	Continued From page 27 - Maintain quick access to resident records. - Support with documentation when needed. Concierge/Administrative: - Provide with documentation as needed during emergencies. - Ensure the front desk binder remains accessible and properly labeled. - Maintain awareness and follow established emergency escalation protocols - Notify the DOHW [Director of Health and Wellness] immediately if any issues are identified with binder accuracy, accessibility, or labeling. 1. Determine / Status a. Immediately verify whether the resident has a valid on file. b. Contact the following, in order to confirm the resident's current status: i. Nurse on Duty, Med Tech or Health & Wellness (H&W) Team - verify in the resident's electronic medical record (Eldermark) or binder. ii. If the H&W team is unavailable, contact the Concierge/Receptionist to access the resident file or binder. iii. If still unclear, escalate immediately to the Executive Director for direction. c. Once confirmed, proceed according to the presence or absence of a valid . 2. If valid present: a. Do not perform . b. Call 911 and notify . c. Provide with resident's sheet, medication list, and (concierge, if not H&W Team member, pull from the binder located at the Concierge/Front Desk). d. Document actions and notifications. 3. If no present: a. Begin and follow emergency care	A 076		

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

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A 076	Continued From page 28 policies and procedures. 4. Primary Emergency Response: a. The Health & Wellness Team is responsible for preparing and providing : i. Resident's sheet ii. Medication list iii. document, if applicable b. Alternate Emergency Response (role order): i. If the Nurse on staff is available, the Nurse provides the required documents to . ii. If no Nurse is present, the Medication Technician provides the documents. iii. If neither is available, the Concierge/Receptionist provides the documents." During an interview on at 12:34 PM with the Director of Nursing, she was asked who would be in charge of providing with a resident's , to which she confirmed that the concierge is to assist with providing the with the copy. She confirmed that the facility had a binder of all the resident's on each floor. A review of the "New Hire Orientation : ..." attendance sheet revealed that Staff B was in attendance. A review of the " Training " attendance sheet revealed that Staff C was in attendance. A review of Staff D's employee record revealed that she had a completed certificate for one hour of " - " dated , that covered topics listed as "Facility Policies and Procedures, Honoring the Order, Law and Forms and Liability." A review of Staff E's employee record revealed	A 076		

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A 076	Continued From page 29 that she had a completed certificate for one hour of " - " dated , that covered topics listed as "Facility Policies and Procedures, Honoring the Order, Law and Forms and Liability." Class I	A 076		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.	A 077		

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A 077	Continued From page 30 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to [illegible], are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the [illegible] of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the	A 077		

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A 077	Continued From page 31 individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which	A 077		

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A 077	Continued From page 32 is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure that it was under the supervision of an administrator who was capable of managing operations, including the oversight of all staff to ensure that its policies and procedures were followed. ( ) policies and procedures were not followed, which resulted in Emergency Medical Services ( ) to not have received Resident #1's properly executed and initiating resuscitative measures; placing 31 of 57 total residents, who had a in place, at risk (Residents #4, 6, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37). Findings include: A review of the internal incident report revealed that on , staff responded to Resident #1's room due to a report of difficulty breathing. The resident was found to be , to verbal commands and Emergency Medical Services ( ) were called. arrived and transported the resident to the Hospital. The Hospital later notified the facility that Resident #1 expired at 8:45 AM. The report failed to mention A review of Resident #1's hospital record dated revealed that Resident #1 presented to the Hospital Emergency Department (ED), where "[Resident 1] went to , got epi and	A 077		

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A 077	Continued From page 33 had return of spontaneous regulation but then he did not have a , when he arrived. While here in the ER the patient was with [, ,] and he was given multiple doses of , , as well as bicarb." Further review revealed that " started in truck". A review " ( ) Orders & Advance Directives Medical Emergency Internal Procedures" revealed that "Concierge/Administrative ... Notify the DOHW [Director of Health and Wellness] immediately if any issues are identified with binder accuracy, accessibility, or labeling." During an interview on at 10:51 AM with Staff E (Concierge) she was asked what the front desk's responsibilities were when is called to the facility, she stated that they would print a copy of the sheet, the medication list and a copy of the ( ); she stated that sometimes if they do not have it ready, the nurses would give it to them [ ] upstairs. She further stated, "That day we did not give it to them because the printer was acting up, so the documentation was given to them upstairs". There was no mention that the Director of Health and Wellness was notified. During an interview on with Staff B (Registered Nurse) he was asked if he informed that Resident #1 had a , he stated that he did not tell them verbally, but he thought that they received a copy. He further stated that he could not recall who provided the with the paper. During an interview on at 12:34 PM with the Director of Nursing, she was asked who	A 077		

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A 077	Continued From page 34 would be in charge of providing with a resident's , to which she confirmed that the concierge is to assist with providing the with the copy. A review " ( ) Orders & Advance Directives Medical Emergency Internal Procedures" revealed "b. Alternate Emergency Response (role order) i. If the Nurse on staff is available, the Nurse provides the required documents to . ii. If no Nurse is present, the Medication Technician provides the documents. iii. If neither is available, the Concierge/Receptionist provides the documents." During an interview on at 12:34 PM with the Administrator, she was informed that facility staff failed to follow the facility's policies and procedures. She stated that the staff completed in-service training for ( ) following the events that led Resident #1 to receive life saving measures, despite having had a properly executed . A review of the facility's binder revealed that there were properly executed 's for 31 out of 57 total residents; Residents 4, 6, 7, 8, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36 and 37. Class II	A 077		
A 078 SS=G	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement	A 078		

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A 078	Continued From page 35 from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule	A 078		

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A 078	Continued From page 36 chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility to ensure four out of ten sampled staff (Staff B, C, D, E) were qualified to perform their assigned duties according to their level of education, training, preparation, and experience. Additionally, staff failed to follow policy by not providing Resident #1's ( ) to Emergency Medical Services ( ) during an emergency. Findings Included: A review of Resident 1's records revealed that the resident on and had a ( ) on file. Also, Resident #1 was not feeling well the previous day on and noted that Resident #1 was	A 078		

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A 078	Continued From page 37 experiencing , , . A review of the hospital records dated showed that Resident #1 arrived at 7:48 AM via Fire Rescue while intubated. , , ( ) had been initiated in the ambulance after the resident went into , and received 2 doses of , , and 2 grams of , . In the Emergency Department, continued , additional , , , and . After about 45 minutes of combined prehospital and hospital efforts, the attending physician determined further was futile, and the patient was pronounced at 8:34 AM. Interviewed on at 1:39 PM Staff C (Medication Technician) stated that he was notified by another member of staff that Resident #1 was unstable. Staff C stated he contacted Staff B (Registered Nurse/ Supervisor) via radio and asked him to come to the resident room. Staff C stated he left the resident room after Staff B arrived and then proceeded to gather the resident factsheet and medication list for Emergency Medical Services ( ). When asked whether he had performed on the resident, Staff C stated, "I'm sorry can you call me ? Just give me a moment. My is in an emotional state right now. I'm just trying to see ..." After multiple attempts to ask if Staff C had performed on Resident #1, no further response was obtained at that time. During an interview, on at 10:07 AM Staff B (Registered Nurse/ Supervisor), stated that he did not verbally advise Emergency Medical Services ( ) of the resident's	A 078		

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A 078	Continued From page 38 status. Staff B further stated, "I don't remember if I gave the advance directive document." During Interviews on from 10:45 AM through 10:51 AM with Staff D (Concierge) and Staff E (Concierge), both staff members stated that they normally provide with the resident's sheet and medication list. Staff E further stated that is also required to receive the residents' documentation. Regarding the incident on with Resident #1, Staff E stated that the printer was not working and, therefore, they were unable to provide the documentation to before left the facility. Staff E stated, " arrived too fast, and I thought the paperwork was being provided from the upstairs fourth floor nursing station." According to the Department of Health, "A ( ) is a form or patient identification device developed by the Florida Department of Health to identify people who do not wish to be in the event of , , or ." The form authorizes withholding measures, including , , , , , and in the event of or , , . Observation on at 10:30 AM showed at the concierge/ front desk Staff D grabbed a white binder that contained the 's of assisted living and independent living residents. Interviewed on at 12:21 PM the Director of Health & Wellness stated that the facility's process if the nurse was not present, the concierge/ front desk staff would provide the documentation.	A 078		

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A 078	Continued From page 39 A review of the facility's orders & Advance Director Medical Emergency policy showed, "Emergency Response: 3. Determine ? status d. Immediately verify if the resident has a valid on file. e. Contact the following, in order to confirm the resident's current status: . Nurse on Duty, Med Tech or Health & Wellness (H&W) team- verify in the resident's electronic medical record (Eldemark) or binder. v. If the H&W team is unavailable, contact the Concierge/Receptionist to access the resident file or binder. vi. If still unclear escalate immediately to the Executive Director for direction. f. Once confirmed, proceed according to the presence or absence of a valid . 4. If valid present: d. Do not perform . e. Call 911 and notify . f. Provide with resident's sheet, medication list, and (concierge, if not H&W Team member, pull from the binder located at the Concierge / Front Desk)" Further review of the facility's orders & Advance Director Medical Emergency policy showed, " / Advance Directive Binder Policy: Concierge / Front Desk Binder . Clearly labeled: " Binder-Confidential." . Located at the concierge or front desk, accessible to 24/7. . Contains copies of current resident /Advance Directive forms. . Forms are stored alphabetically by last name.	A 078		

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A 078	Continued From page 40 Memory Care (MC) Neighborhood Binder . Separate binder located in the MC unit. . Clearly labeled: " Binder-Confidential." . Located at the nurse's station in the memory care neighborhood, accessible to 24/7. . Contains copies on current resident /Advance Directive forms specific to MC residents. . Forms are stored alphabetically by last name." A review of Staff B's personnel records showed a hire date of and current in-service training dated . A review of Staff C's personnel records showed a hire date of and current in service training dated . A review of Staff D's personnel records showed a hire date of and current training dated . A review of Staff E's personnel records showed a hire date of and current training dated . Class II	A 078		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good	A 152		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND LIVING 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 152	Continued From page 41 working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a safe, clean environment and failed to ensure hazardous materials were secured and inaccessible to residents for two out of 37 samples residents. (Residents #7 and 8). Findings Included:	A 152		

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 _____	06/04/2026

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A 152	Continued From page 42 During the facility tour on at 7:15 a.m., was observed in Resident #8, stains on the wall behind the recliner and near the dining table. On at 7:26 a.m. was observed in where Resident #7 resides was a cabinet in a kitchen area with untied, hanging lock chains. The cabinet door opened easily, and it was observed cleaning supplies Layson All Purpose Cleaning inside, making hazardous chemicals accessible to Resident #7. Record review of Resident #7's Health Assessment Form 1823 showed medical diagnoses of unspecified and major . The assessment documented the resident as alert and oriented ×2 with physical and sensory limitations requiring the use of a wheelchair, walker, and glasses. During an interview at 12:20 p.m. on , The Administrator stated, the stains on the wall in resident #8, "It could be from opening and closing the door". During an interview at 12:21 p.m. on , the Administrator stated that a lock in Resident #7 had been placed as a precautionary measure, and the resident did not have any condition requiring a lock. The Administrator further stated that the resident's room door was always locked. Class III	A 152		