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 |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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<br><br>Assisted Living Facility<br><br>A biennial state licensure survey with extended congregate care (ECC) and limited mental health (LMH) services was conducted on 10/1... ... conjunction with a complaint survey, CCR# 2012008578, see Aspen Event BFDY11.<br><br>The Emerald Gardens assisted living facility had deficiencies found at the time of the visit. | A 000 | | |
| A 009 | 58A-5.0181(3) FAC Admissions - Admission Package<br><br>(3) ADMISSION PACKAGE.<br>(a) The facility shall make available to potential residents a written statement(s) which includes the following information listed below. A copy of the facility resident contract or facility brochure containing all the required information shall meet this requirement.<br>1. The facility ' s residency criteria;<br>2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provide by the facility for that rate;<br>3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any;<br>4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any;<br>5. Food service and the ability of the facility to accommodate special diets;<br>6. The availability of transportation and additional costs to the resident, if any;<br>7. Any other special services that are provided by the facility and additional cost if any;<br>8. Social and leisure activities generally offered | A 009 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 009 | Continued From page 1 | A 009 | | |

by the facility;
9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any;
10. A statement of facility rules and regulations that residents must follow as described in Rule 58A-5.0182, F.A.C.;
11. A statement of the facility policy concerning [redacted] pursuant to Section 429.255, F.S. and Rule 58A-5.0186, F.A.C., and Advance Directives pursuant to Chapter 765, F.S.
12. If the facility also has an extended congregate care program, the ECC program ' s residency criteria; and a description of the additional personal, supportive, and nursing services provided by the program; additional costs; and any limitations, if any, on where ECC residents must reside based on the policies and procedures described in Rule 58A-5.030, F.A.C.;
13. If the facility advertises that it provides special care for persons with [redacted] and related [redacted], a written description of those special services as required under Section 429.177, F.S.; and
14. A copy of the facility ' s resident elopement response policies and procedures.
(b) Prior to or at the time of admission, the resident, responsible party, guardian, or attorney in fact, if applicable, shall be provided with the following:
1. A copy of the resident ' s contract which meets the requirements of Rule 58A-5.025, F.A.C.;
2. A copy of the facility statement described in paragraph (a) of this subsection if one has not already been provided;
3. A copy of the resident ' s bill of rights as required by Rule 58A-5.0182, F.A.C.; and
4. A Long-Term Care Ombudsman Council brochure which includes the telephone number and address of the district council.

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 |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 009 | Continued From page 2<br><br>(c) Documents required by this subsection shall be in English. If the resident is not able to read, or does not understand English and translated documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review the facility did not ensure the admissions packet provided to the resident or the resident's power of attorney/family member had information related to the facility's Extended Congregate Care services including rates, policy and procedures related to information pertaining to advanced directives, policy and procedures related to elopements and house rules.<br><br>Findings include:<br><br>A review of the facility's admission packet was conducted on at 3:30 p.m. The following required items were not found in the admissions packet:<br>- the facility's Extended Congregate Care (ECC)criteria for admission, services provided including rates and limitations to the ECC services.<br>- the facility's policy and procedures related to<br><br>- information pertaining to advanced directives<br>- policy and procedures related to elopements<br>- a copy of the facility's resident rules.<br><br>The Assistant Administrator confirmed this documentation was not provided in the admission packet. | A 009 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 009 | Continued From page 3<br>Class III<br><br>Widespread | A 009 | | |
| A 010 | 58A-5.0181(4) FAC Admissions - Continued Residency<br><br>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement.<br>(a) The resident may be bedridden for up to 7 consecutive days.<br>(b) A resident requiring care of a pressure may be retained provided that:<br>1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care;<br>2. The condition is documented in the resident ' s record; and<br>3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility. | A 010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 010 | Continued From page 4<br>(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:<br>1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;<br>2. Continued residency is agreeable to the resident and the facility;<br>3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and<br>4. Documentation of the requirements of this paragraph is maintained in the resident ' s file.<br>(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.<br>(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.<br>(5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to insure that two of eight | A 010 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 010 | Continued From page 5 | A 010 | | |

sampled residents (Resident #3 and Resident #8) were appropriate for continued residency due to the physical condition of Resident #3 and the inability to provide security and prevent elopement of Resident #8. Failure to insure residents are appropriate to reside in an assisted living facility can place residents at risk of harm if they do not receive the level of care they require.

Findings include:

During a tour of the facility on [redacted] at 9:20 a.m., AHCA staff observed Resident #3 in her bed in her [redacted]. AHCA staff attempted to interview Resident #3 but the resident did not respond to questions. At 12:15 p.m., Resident #3 was in the dining [redacted]. A staff person sat beside the resident throughout the meal and fed her.

AHCA staff interviewed Employee C at 1:05 p.m. Employee C stated that Resident #3 "barely talks" and requires total care with bathing, dressing, transferring and feeding.
AHCA staff interviewed Employee E at 3:20 p.m. Employee E stated that Resident #3 does not always get up for meals because it was easier to just let her stay in bed. Employee E stated facility staff check on her and "turn her" regularly. Employee E said that Resident #3 is difficult to transfer because she is "stiff".

AHCA staff reviewed the record for Resident #3. Resident #3 has been receiving [redacted] care for two [redacted] one on her [redacted] and one on her [redacted]. The [redacted] care notes describe the resident as "bedbound." The resident's initial health assessment from [redacted] indicates that at that time, the resident ate independently and required assistance for transferring, bathing and dressing.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 010 | Continued From page 6 | A 010 | | |

On , AHCA staff reviewed the record for Resident #8. AHCA staff noted that Resident #8 eloped from the facility on at least 4 occasions and law enforcement was involved in locating the resident. The facility Administrator was interviewed at 9:10 a.m. and verified the resident's repeated elopements. He stated "We had a Wanderguard on her but she managed to get it off." He confirmed that there is no security mechanism other than the Wanderguard to prevent residents from walking out the front door. As of (date the resident was moved by family to a secured ALF) the facility had not installed a security locking system to prevent elopements.

A progress note written by the resident's physician on noted "Patient very agitated, walked out today, and brought back, then she hit one of (the) employees." On another physician progress note states "Patient is prone to elopement...(another agency) asked to speak to son, and the owner of ALF to see if further precautions can be taken or move the patient to another locked facility."

During an interview on at 3:20 p.m., Employee E stated that it was very difficult to keep Resident #8 from leaving the facility because "you couldn't take your eyes off of her." When interviewed on at 3:30 p.m. regarding Resident #8, the Assistant Administrator acknowledged that the wander guard the facility had was not adequate to prevent Resident #8 from leaving the facility. A notice to discharge the resident with a 45 day notice had not been followed through by facility management in view of the risk to the resident with exit seeking behaviors in a non-secured facility.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 010 | Continued From page 7<br><br>Class III<br><br>Pattern | A 010 | | |
| A 030 | 58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures<br><br>(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(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 Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C.<br>(b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.<br>(c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with Disabilities, 1(800)34 the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.<br>(d) The statewide toll-free telephone number of the Florida Abuse Hotline " -ABUSE or 32-2873 " shall be posted in full view in a common area accessible to all residents.<br>(e) The facility shall have a written statement of | A 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 030 | Continued From page 8 | A 030 | | |

its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.

(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.

(g) The facility shall 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 shall not prohibit 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 shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.

(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 030 | Continued From page 9<br><br>429.28 Resident bill of rights.-<br>(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:<br>(a) Live in a safe and decent living environment, free from and neglect.<br>(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.<br>(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.<br>(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 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.<br>(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.<br>(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.<br>(g) Share a his or her spouse if both | A 030 | | |

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 |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 030 | Continued From page 10 | A 030 | | |

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) Access to adequate and appropriate health care 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, 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 shall be set forth in writing. 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 030 | Continued From page 11<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to honor the resident rights for one of seven sampled residents (Resident #3) by obtaining a written order from a physician authorizing the use of half-bed rails.<br><br>Findings include:<br><br>During a tour of the facility conducted on at approximately 9:30 a.m., AHCA staff observed Resident #3 lying in bed and noted the bed had half-bed rails.<br><br>AHCA staff reviewed the record for Resident #3 and there was no written order from the physician authorizing the use of half-bed rails.<br><br>When interviewed on at approximately 3:30 p.m., the Administrator acknowledged the findings.<br><br>Class III | A 030 | | |
| A 053 | 58A-5.0185(4) FAC Medication - Administration<br><br>(4) MEDICATION ADMINISTRATION.<br>(a) For facilities which provide medication administration a staff member, who is licensed to administer medications, must be available to administer medications in accordance with a health care provider ' s order or prescription label.<br>(b) Unusual reactions or a significant change in the resident ' s health or behavior shall be | A 053 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 053 | Continued From page 12<br>documented in the resident ' s record and reported immediately to the resident ' s health care provider. The contact with the health care provider shall also be documented in the resident ' s record.<br>(c) Medication administration includes the conducting of any examination or testing such as [redacted] glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff.<br>(d) A facility which performs clinical laboratory tests for residents, including [redacted] glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State Clinical Laboratory License and the CLIA Certificate must be maintained in the facility. A state license or CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents ' own equipment. Information about the State Clinical Laboratory License and CLIA Certificate is available from the Clinical Laboratory Licensure Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)487-3109.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to have licensed, qualified staff administer medication to one of seven sampled residents (Resident #1). Failure to have qualified staff administer medications can | A 053 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 053 | Continued From page 13<br>put residents at risk of harm through medication errors.<br><br>Findings include:<br><br>On at approximately 9:15 a.m., AHCA staff interviewed Employee A. Employee A stated that Resident #1 took daily. Employee A stated that staff from a home health agency "sometimes gave it to her" or Resident #1 administered it herself, with assistance.<br><br>On AHCA staff reviewed the home health sign-in sheets for the facility from through No home health staff signed in to provide services to Resident #1.<br><br>On at 1:15 p.m., AHCA staff attempted to interview Resident #1. Resident #1 gave answers to the questions. AHCA staff observed that Resident #1's left arm and hand were contracted along her side. Resident #1 attempted to pick up a spoon with her left hand and was unable to do so.<br><br>On at approximately 1:40 p.m., AHCA staff interviewed Employee A a second time. Employee A stated that she regularly administers to Resident #1. Employee A stated that she is not a nurse and is not licensed.<br><br>Class III | A 053 | | |
| A 055 | 58A-5.0185(6) FAC Medication - Storage and Disposal<br><br>(6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and | A 055 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 055 | Continued From page 14 | A 055 | | |

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; or in their . . . . . or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the . . . . . or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if:
1. The facility administers the medication;
2. The resident requests central storage. The facility shall 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 prior to admission as required under Rule 58A-5.0181, F.A.C.
(b) Centrally stored medications must be:
1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 055 | Continued From page 15<br>being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;<br>3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and<br>4. Kept separately from the medications of other residents and properly closed or sealed.<br>(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider.<br>(d) When a resident ' s stay in the facility has ended, the administrator shall 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 shall be considered abandoned and may disposed of in accordance with paragraph (e).<br>(e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one | A 055 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 055 | Continued From page 16<br>witness.<br>(f) 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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review the facility did not ensure ensure expired medications had been properly disposed within 30 days of expiration and/or abandoned medications disposed of within 15 days of resident discharge from the facility. Failure to properly dispose of expired medications could result in residents receiving medications with reduced efficacy.<br><br>Findings include:<br><br>A medications cart review was conducted with the Facility Manager on 10/1[illegible] following items were found to be in the medications drawer for current residents with expiration dates as<br>- Acetaminophen [illegible] mg tablets expired 05/1[illegible]<br>- [illegible] mg expired 09[illegible]<br>- Alprazolam [illegible] mg expired 05/1[illegible]<br>- [illegible] mg EC [illegible] 03/1[illegible]<br>- [illegible] mg expired 02/1[illegible]<br>- [illegible] expired 10/0[illegible]<br><br>[illegible] following expired medications found in the medication cart were identified as belonging to residents who were no longer in the facility and had been discharged greater than 15 days:<br>- Procrit [illegible]00 injectable expired 07/0[illegible]<br>- [illegible].5 mg expired 11/2[illegible]<br>- Acetaminophen [illegible] expired 04/0[illegible]<br>- [illegible] mg suppositories expired 06/0[illegible] | A 055 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 055 | Continued From page 17<br><br>The Facility Manager stated "I just haven't gotten around to getting rid of these medications. I'll get it done now." The Assistant Administrator was witness to the process of reviewing all of the medications removed from the medication cart for proper disposal.<br><br>Class III | A 055 | | |
| A 056 | 58A-5.0185(7) FAC Medication - Labeling and Orders<br><br>(7) MEDICATION LABELING AND ORDERS.<br>(a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is 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:<br>1. The resident ' s name; and<br>2. Identification of each medicinal drug product in the container.<br>(b) Except with respect to the use of pill organizers as described in subsection (2), no person other than a pharmacist may transfer medications from one storage container to another.<br>(c) If the directions for use are " as needed " or " as directed, " the health care provider shall 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 shall be specified; | A 056 | | |

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 |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 056 | Continued From page 18<br>for example, " as needed for pain, 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, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.<br>(d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident ' s health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident ' s medication observation record. The facility may then place an " alert " label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.<br>(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 copy of a signed order is acceptable.<br>(f) The facility shall 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.<br>(g) Pursuant to Section 465.0276(5), F.S., and Rule 64F-12.006, 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 shall also include the practitioner ' s name, the resident ' s name for whom they were dispensed, and the date they were dispensed. If | A 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 056 | Continued From page 19 | A 056 | | |

the sample or complimentary prescription drugs are not dispensed in the manufacturer ' s labeled package, they shall be kept in a container that bears a label containing the following:
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 shall provide the resident with a written prescription, or a fax copy of such order.

This Statute or Rule is not met as evidenced by:
Based on observation interview and record review the facility failed to ensure one (#5) of 8 sampled residents was receiving medication at a time as ordered by the physician'

Findings include:

A medication pass was observed on [redacted] at 12 noon. The Facility Manager was observed providing assistance with the self-administration of 2 medications for resident #8. One of the medications was [redacted] ER (extended release) 10 mEq tablets. A review of the residents Medication Observation Record (MOR) notes the resident was to receive "3 tablets by mouth in the morning, 4 tablets at lunchtime and 4 tablets at dinner." The times marked on the MOR indicate the resident has been given the medications to take at 8:00 a.m. ("in the morning"), at 12:00 p.m. ("at lunchtime") and 8:00 p.m. The Facility Manager and the Assistant Administrator acknowledged that dinner in the facility is served at 5:00 p.m. They were

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 056 | Continued From page 20<br><br>unaware that the order states "4 tablets at dinner" yet the documentation indicates the resident is taking 4 tablets at 8:00 p.m. which is 3 hours after dinner. The Facility Manager confirmed the resident takes his medication at 8:00 p.m. The facility manager stated "I'll have to talk to the pharmacy."<br><br>Additionally the facility was dispensing this medication to resident #8 from a bottle with directions indication one tablet twice a day. New labeling had not been received or noted when the physician changed the order on .<br><br>Class III | A 056 | | |
| A 057 | 58A-5.0185(8) FAC Medication - Over The Counter (OTC) Products<br><br>(8) OVER THE COUNTER (OTC) PRODUCTS. For purposes of this subsection, the term OTC includes, but is not limited to, OTC medications, , nutritional supplements and nutraceuticals, hereafter referred to as OTC products, which can be sold without a prescription.<br>(a) A stock supply of OTC products for multiple resident use is not permitted in any facility.<br>(b) OTC products, including those prescribed by a licensed health care provider, must be labeled with the resident ' s name and the manufacturer ' s label with directions for use, or the licensed health care provider ' s directions for use. No other labeling requirements are necessary nor should be required.<br>(c) Residents or their representatives may purchase OTC products from an establishment of their choice. | A 057 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 057 | Continued From page 21<br>(d) A facility cannot require a licensed health care provider ' s order for all OTC products when a resident self-administers his or her own medications, or when staff provides assistance with self-administration of medications pursuant to Section 429.256, F.S. A licensed health care provider ' s order is required when a licensed nurse provides assistance with self-administration or administration of medications, which includes OTC products. When such an order for an OTC product exists, only the requirements of paragraphs (b) and (c) of this subsection are required.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview the facility did not ensure over the counter, non-prescription medications used by residents, which have been either purchased for personal use by the resident or the resident's family, were labeled with the residents name. Additionally the facility did not ensure syringes, lancets and glucose test strips were either not removed from the original resident labeled box or had the resident's name clearly labeled for their use only on the items.<br><br>Findings include<br><br>A medications cart review was conducted with the Facility Manager on The following over the counter purchased items were found in the medication cart to be unlabeled with the resident names clearly written on the bottles/containers:<br>- 325 mg (large bottle)<br>- tablets 50 mg<br>- tablets 100 mg<br>C<br>-<br>- 500 mg gelcaps | A 057 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 057 | Continued From page 22<br><br>- Spectravite Senior<br>- Cranberry supplement 500 mg<br>D3 1000 iu<br>- 10 mg suppositories<br>- Vaporizing chest rub<br><br>Additionally the following items were found in various drawers in the medication cart and also not labeled to identify the resident:<br>- 2 bottles of glucose test strips unlabelled and expired<br>- 4- 1/2 cc syringes loose with no resident name<br>- 2- 1 cc syringe loose with no resident name<br>- 5 3 ml 22 gauge syringe and needle loose with no resident name<br><br>The Facility Manager stated "I didn't know I had to have the residents' names on the things the family brings in since I store them in their (the residents') own section. I'll get it done now." The assistant administrator was witness to the process of reviewing all of the medications and the removal of the unlabelled lancets, test strips and syringes.<br><br>Class III<br><br>Pattern | A 057 | | |
| A 075 | 429.255 FS Use of Personnel; Emergency Care<br><br>Use of personnel; emergency care.-<br>(3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). | A 075 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 075 | Continued From page 23<br>(b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical director.<br>(c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility.<br>(4) Facility staff may withhold or withdraw or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The department shall adopt rules providing for the implementation of such orders. Facility staff and facilities shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing or use of an automated external defibrillator pursuant to such an order and rules adopted by the department. The absence of an order to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing or use of an automated external defibrillator as otherwise permitted by law.<br>(5) The Department of Elderly Affairs may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview the facility with a capacity of 20 residents did not ensure a functioning automatic external defibrillator (AED) | A 075 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 075 | Continued From page 24<br>was available in the facility for emergency use which may result in a resident not receiving emergency [illegible] in the event of a [illegible] which can result in [illegible].<br><br>Findings include:<br><br>A tour of the facility was conducted on [illegible]. An automatic external defibrillator was not seen in the area toured nor was there signage to indicate the location of the [illegible]. The facility's Assistant Administrator was asked at approximately 3:00 p.m. to identify the location of the [illegible] and stated "We don't have one. I didn't know we needed something like that."<br><br>Class III<br><br>Widespread | A 075 | | |
| A 076 | 58A-5.0186 FAC [illegible]<br><br>(1) POLICIES AND PROCEDURES.<br>(a) Each assisted living facility (ALF) must have written policies and procedures, which delineate its position with respect to state laws and rules relative to [illegible]. The policies and procedures shall not condition treatment or admission upon whether or not the individual has executed or waived a [illegible]. The ALF must provide the following to each resident, or resident's representative, at the time of admission:<br>1. A copy of Form SCHS-4-2006, "Health Care Advance Directives - The Patient's Right to Decide, " [illegible] 2006, or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in Chapter 765, F.S. Form | A 076 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 076 | Continued From page 25<br>SCHS-4-2006 is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308, or the agency ' s Web site at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and<br>2. Written information concerning the ALF ' s policies regarding ; and<br>3. Information about how to obtain DH Form 1896, Florida Form, incorporated by reference in Rule 64J-2.018, F.A.C.<br>(b) There must be documentation in the resident ' s record indicating whether or not he or she has executed a . If a has been executed, a copy of that document must be made a part of the resident ' s record. If the ALF does not receive a copy of a resident ' s executed , the ALF must document in the resident ' s record that it has requested a copy.<br>(2) LICENSE REVOCATION. An ALF shall be subject to revocation of its license pursuant to Section 408.815, F.S., if, as a condition of treatment or admission, it requires an individual to execute or waive a<br>(3) PROCEDURES. Pursuant to Section 429.255, F.S., an ALF must honor a properly executed as follows:<br>(a) In the event a resident experiences , staff trained in , or a licensed health care provider present in the facility, may withhold<br>(b) In the event a resident is receiving hospice services and experiences , facility staff must immediately contact the hospice. The hospice procedures shall take precedence over those of the assisted living | A 076 | | |

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 |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 076 | Continued From page 26<br><br>facility.<br>(4) LIABILITY. Pursuant to Section 429.255, F.S., ALF providers shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for following the procedures set forth in subsection (3) of this rule, which involves withholding or withdrawing<br>pursuant to a<br>and rules adopted by the department.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review the facility did not ensure a policy and procedure which delineates the facility's position relative to<br>)s)was had been written.<br><br>Findings include:<br><br>A review of the facility's admission packet was conducted on at 3:30 p.m. A copy of the facility's policy and procedures stating the facility's position related to was not found in the admission packet. The Assistant Administrator was asked to provide the documentation and stated "We don't have a policy like that. I didn't know we needed it." The surveyor also did not find any evidence that the facility had provided the resident and or the resident's power of attorney/family member with information related to advanced directives.<br><br>Class III<br><br>Widespread | A 076 | | |

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 |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 078 | 58A-5.019(2) FAC Staffing Standards - Staff<br><br>(2) STAFF.<br>(a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable including Freedom from must be documented on an annual basis. A person with a positive test must submit a health care provider ' s statement that the person does not constitute a risk of communicating Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable he/she shall be removed from duties until the administrator determines that such condition no longer exists.<br>(b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall 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 chapter.<br>(c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C.<br>(d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall | A 078 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 078 | Continued From page 28<br><br>specifically describe the services the staffing agency or contractor will be providing to residents.<br>(e) For facilities with a licensed capacity of 17 or more residents, the facility shall:<br>1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and<br>2. Maintain time sheets for all staff.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to insure that staff were free from and communicable within 30 days of hire. The facility also failed to insure that all staff submitted documentation that they were free of on an annual basis. Failure to insure staff are free of and communicable can place residents at risk of illness.<br><br>Findings include:<br><br>On , AHCA staff reviewed the employee file for Employee A, hired . The file contained documentation that Employee A had a chest x-ray on . The file also contained documentation from a physician dated and indicating Employee A was free from and communicable There was no documentation from within the last twelve months indicating Employee A was free of .<br><br>On , AHCA staff reviewed the employee file for Employee B, hired . The file did not contain any documentation of a test or any communicable statement.<br><br>When interviewed on at approximately 11:45 a.m., the Administrator | A 078 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 078 | Continued From page 29<br>acknowledged the findings.<br><br>Class III<br><br>Pattern | A 078 | | |
| A 081 | 58A-5.0191(2) FAC Training - Staff In-Service<br><br>(2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:<br>(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne may be used to meet this requirement.<br>(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Reporting major incidents.<br>2. Reporting adverse incidents.<br>3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.<br>(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Resident rights in an assisted living facility.<br>2. Recognizing and reporting resident | A 081 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | 10/15/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 081 | Continued From page 30<br><br>neglect, and<br>(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:<br>1. Resident behavior and needs.<br>2. Providing assistance with the activities of daily living.<br>(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.<br>(f) All facility staff shall receive in-service training regarding the facility ' s resident elopement response policies and procedures within thirty (30) days of employment.<br>1. All facility staff shall be provided with a copy of the facility ' s resident elopement response policies and procedures.<br>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to insure that three of three sampled staff (Employees A, C) completed the required staff in-service trainings within thirty days of employment. Failure to insure that staff receive required training can place residents at risk of harm.<br><br>Findings include: | A 081 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 081 | Continued From page 31<br><br>AHCA staff reviewed the employee files for Employees A, B and C on AHCA staff noted the following:<br><br>Employee A was hired Employee A's employee file did not contain any documentation of completed training on control or recognizing and reporting resident neglect and<br><br>Employee B was hired on Employee B's employee file did not contain any documentation of completed training on control, reporting major incidents or the facility's emergency and evacuation procedures.<br><br>Employee C was hired on Employee C's employee file did not contain any documentation of completed training on reporting major incidents.<br><br>The Administrator was interviewed about the training on at approximately 11:45 a.m. and acknowledged the findings.<br><br>Class III<br><br>Widespread | A 081 | | |
| A 083 | 58A-5.0191(4) FAC Training - First Aid and<br><br>(4) FIRST AID AND A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times.<br>(a) Documentation of attendance at First Aid or course offered by an accredited college, | A 083 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 083 | Continued From page 32<br><br>university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement.<br>(b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to insure that a staff member with a currently valid card indicating they were trained in First Aid and was present in the facility at all times. Failure to insure that an employee with First Aid and training is present can place residents at risk of harm if an emergency arises.<br><br>Findings include:<br><br>On AHCA staff reviewed the facility staffing schedule and noted that Employee B is the only employee scheduled from approximately 8:00 PM - 7:00 AM.<br>On 10/15, staff reviewed the employee file for Employee B. Employee B's CPR expired on 11/19/<br><br>Administrator was interviewed on 10/15 approximately 11:45 a.m. and acknowledged the findings.<br><br>Class III | A 083 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 083 | Continued From page 33<br>Widespread | A 083 | | |
| A 090 | 58A-5.0191(11) FAC Training - Do Not Orders<br><br>(11) TRAINING.<br>(a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policies and procedures regarding within 60 days after the effective date of this rule.<br>(b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policy and procedures regarding within 30 days after employment.<br>(c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review, the facility failed to insure that three of three sampled direct care staff (Employees A, B and C) received at least one hour of training in the facility's policy and procedures regarding<br><br>Findings include:<br><br>AHCA staff reviewed the employee record for Employee A on The employee record did not contain any documentation of training on On that same date, AHCA staff reviewed the employee record for Employee | A 090 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 090 | Continued From page 34<br><br>B. The record did not contain documentation of training on _____. AHCA staff also reviewed the employee record for Employee C on the same date. The record did not contain any documentation of training on _____.<br><br>The facility Administrator was interviewed about _____ training on _____ at approximately 11:45 a.m. The administrator acknowledged the findings and confirmed that none of the staff had completed training on _____.<br><br>Class III<br><br>Widespread | A 090 | | |
| A 093 | 58A-5.020(2) FAC Food Service - Dietary Standards<br><br>(2) DIETARY STANDARDS.<br>(a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, ___ and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program.<br>(b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: | A 093 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 093 | Continued From page 35 | A 093 | | |

1. Protein: 6 ounces or 2 or more servings;
2. Vegetables: 3 5 servings;
3. Fruit: 2 4 or more servings;
4. Bread and starches: 6 11 or more servings;
5. Milk or milk equivalent: 2 servings;
6. Fats, oils, and sweets: use sparingly; and
7. Water.

(c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.

(d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months.

(e) Therapeutic diets shall be prepared and served as ordered by the health care provider.

1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 093 | Continued From page 36 | A 093 | | |

document what is eaten unless a health care provider ' s order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility.
2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary.
(f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand.
(h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 093 | Continued From page 37<br><br>canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to meet dietary standards for the residents by not serving the meal posted on the menu and not maintaining an adequate 3-day supply of non-perishable food. Failure to follow the dietary standards can place residents at risk by not providing adequate nutrition.<br><br>Findings include:<br><br>The menu posted at the facility on indicated that lunch that day would consist of pepper steak, rice, wheat roll with margarine, oriental vegetables and fruit salad.<br>At 12:00, AHCA staff observed that the meal served to the residents consisted of pasta, chicken , marinara sauce, roll with margarine, vegetables and jello.<br><br>On , AHCA staff interviewed the Cook and asked if the facility kept a substitution log. The Cook stated they did not. The Cook stated, "We have a menu but we just usually make what they want." | A 093 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 093 | Continued From page 38<br><br>On at 12:25 PM, AHCA staff observed the facility's 3-day supply of emergency food. It was noted that there was not adequate food, especially protein, to feed the residents of the facility for 3 days, as the facility only had 5 small cans of tuna and one jar of peanut butter in their emergency supply.<br><br>The Administrator was interviewed on at 3:10 p.m. and acknowledged the findings.<br><br>Class III<br><br>Widespread | A 093 | | |
| A 162 | 58A-5.024(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name;<br>2.<br>3. Race;<br>4. Date of birth;<br>5. Place of birth, if known;<br>6. Social security number;<br>7. Medicaid and/or Medicare number, or name of other health insurance<br>8. Name, address, and telephone number of next of kin, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and<br>9. Name, address, and phone number of health care provider, and case manager if applicable.<br>(b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C.<br>(c) Any health care provider ' s orders for medications, nursing services, therapeutic diets, or other services to be provided. supervised, or implemented by the | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 162 | Continued From page 39<br>facility that require a health care provider ' s order.<br>(d) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C.<br>(e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C.<br>(f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually.<br>(g) For facilities which will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident ' s contract.<br>(h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C.<br>(i) A copy of the resident ' s contract with the facility, including any addendums to the contract, as described in Rule 58A-5.025, F.A.C.<br>(j) For a facility whose owner, administrator, or staff, or representative thereof serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required under Section 429.27, F.S.<br>(k) For any facility which maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required under Section 429.27, F.S.<br>(l) A copy of Alternate Care Certification for | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 162 | Continued From page 40<br><br>Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services.<br>(m) Documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney where applicable.<br>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required under Rule 58A-5.0181, F.A.C.<br>(o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following:<br>1. A log listing the names of residents participating in this arrangement;<br>2. The resident demographic data required under this subsection;<br>3. The medical examination described in Rule 58A-5.0181, F.A.C.;<br>4. The resident ' s contract described in Rule 58A-5.025, F.A.C.; and<br>5. A health care provider ' s order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.<br>(p) Except for resident contracts which must be retained for 5 years, all resident records shall be retained for 2 years following the departure of a resident from the facility unless it is required by | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 162 | Continued From page 41 | A 162 | | |

contract to retain the records for a longer period of time. Upon request, residents shall be provided a copy of their resident records upon departure from the facility.
(q) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on interview and record review, the facility failed to maintain the required information in the record for three of three sampled residents (Resident #1, Resident #3 and Resident #4). Specifically, the facility failed to document the residents' weights in the record semi-annually.

Findings include:

On , AHCA staff reviewed the resident record for Resident #3. Resident #3's record did not contain any weights. The weight log in the resident record contained multiple entries such as, "10 cm", "10.5 cm" and "10.6 com."
On that same date, AHCA staff reviewed the record for Resident #1. Resident #1's record also did not contain any weights and contained entries with "cm".
On that same date, AHCA staff reviewed the record for Resident #4. Resident #4's record also contained no weight records but had entries on the weight log labeled "cm".

When interviewed on at 2:10 p.m., Employee A stated that when residents were not able to stand independently, staff measured their upper arm and tracked that measurement on the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 162 | Continued From page 42<br>weight log. Employee A acknowledged that the residents had not been weighed.<br><br>Class III<br><br>Pattern | A 162 | | |
| AE210 | 58A-5.0191(7) FAC ECC - Training<br><br>Staff Training Requirements and Competency Test.<br>(7) EXTENDED CONGREGATE CARE TRAINING.<br>(a) The administrator and extended congregate care supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility ' s receiving its extended congregate care license or within 3 months of beginning employment in the facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to April shall not be required to take the assisted living facility core training competency test.<br>(b) The administrator and the extended congregate care supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, psychological, social needs of frail elderly and disabled persons with Alzhei related disorders.<br>All direct care staff providing care to residents in an extended congregate care program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning | AE210 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 |
|---|---|---|---|---|
| AE210 | Continued From page 43<br>employment in the facility. The training must address extended congregate care concepts and requirements, including statutory and rule requirements, and delivery of personal care and supportive services in an extended congregate care facility.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review the facility did not ensure one (staff person B) of 3 staff records sampled had received a minimum of 2 hours of extended congregate care (ECC) training provided by the administrator or ECC supervisor within 6 months of the date of hire in an ECC licensed facility.<br><br>Findings include:<br><br>A staff record review conducted on 10/1[illegible] the facility's Assistant Administrator revealed that Staff person B who was hired on 02/1[illegible] no documentation of having received 2 hours of extended congregate care training within 6 months of the date of hire. The Assistant Administrator stated "I know we have to get that done. The others have had the training."<br><br>Class III<br><br>Isolated<br><br>58A-5.0191(8) FAC LMH - Training<br><br>(8) LIMITED MENTAL HEALTH TRAINING.<br>(a) Pursuant to Section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a | AE210<br><br>AL243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 |
|---|---|---|---|---|
| AL243 | Continued From page 44<br>licensed limited mental health facility, must receive the following training:<br>1. A minimum of 6 hours of specialized training in working with individuals with mental health diagnoses.<br>a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility ' s receiving a limited mental health license or within 6 months of employment in a limited mental health facility.<br>b. Staff in " direct contact " means direct care staff and staff whose duties take them into resident living areas and require them to interact with mental health residents on a daily basis. The term does not include maintenance, food service or administrative staff, if such staff have only incidental contact with mental health residents.<br>c. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to Section 429.52(4), F.S., and subsection (1) of this rule.<br>2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics:<br>a. Mental health diagnoses; and<br>b. Mental health treatment such as mental health needs, services, behaviors and appropriate interventions; resident progress in achieving treatment goals; how to recognize changes in the resident ' s status or condition that may affect other services received or may require intervention; and crisis services and the [redacted] procedures.<br>3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of | AL243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 |
|---|---|---|---|---|
| AL243 | Continued From page 45<br>continuing education required biennially pursuant to Section 429.52(4), F.S., and subsection (1) of this rule.<br>4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement.<br>(b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility ' s personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interview and record review the facility did not ensure 2 (Staff person B and C) of 3 staff records sampled had completed the required 6 hours of specialized mental health training provided by or approved by the Department of Health within 6 months of employment in a limited mental health facility.<br><br>Findings include:<br><br>A staff record review conducted on with the facility's Assistant Administrator revealed that Staff person B who was hired on and Staff person C who was hired on had no documentation of having received 6 hours of limited mental health training provided or approved by the Department of Health within 6 months of the date of hire. The Assistant Administrator concurred that there was no | AL243 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965659 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EMERALD GARDENS INC. | 2159 MCMULLEN BOOTH ROAD CLEARWATER, FL 33759 |

| (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 |
|---|---|---|---|---|
| AL243 | Continued From page 46<br>documentation that the training had been completed by these 2 staff persons.<br><br>Class III | AL243 | | |

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Emerald Gardens Inc.
2159 McMullen Booth Road
Clearwater, FL 33759

Dear Administrator:

Re: Biennial with ECC & LMH & **CCR# 2012008578**

This letter reports the findings of a biennial state licensure survey with extended congregate care (ECC) and limited mental health (LMH) that were conducted on , 2012, by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State Forms 3020

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161