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
	AL11912046	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVEWELL AT CORAL PLAZA	5850 MARGATE BLVD. MARGATE, FL 33063

(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 Change of ownership survey conducted on and Livewell at Coral Plaza, an assisted living facility, had deficient practice found at the time of the visit. This survey was conducted in conjunction with a capacity increase survey and two revisits. Reference those separate reports.	A 000		
A 010 SS=D	58A-5.0181(4) FAC Admissions - Continued Residency (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. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a pressure may be retained provided that: 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;	A 010		

AHCA Form 3020-0001

TITLE (X6) DATE

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

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2. The condition is documented in the resident ' s record; and
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.
(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:
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;
2. Continued residency is agreeable to the resident and the facility;
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
4. Documentation of the requirements of this paragraph is maintained in the resident ' s file.
(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
(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.

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This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure a Health Assessment form was completed on every resident upon significant change and that it is reflective of the resident's current health status and care needs, for 1 out of 20 sampled residents (Resident #15).
The findings include:
Record review indicated an admission date of [redacted] for Resident #15. Review of the resident's health assessment dated [redacted] documented a medical diagnosis of [redacted] and [redacted]. It was also documented the resident only required assistance with all Activities of Daily Living (ADLs). Further record review revealed Resident #15 was admitted/enrolled for hospice services on [redacted]. During an interview with the Director of Nursing (DON) at 12 PM on [redacted], it was revealed the resident was admitted to hospice for [redacted] and a decline in health. It was also revealed the resident now requires total care with all of her ADLs. Further record review failed to indicate a current health assessment reflecting the resident's significant health change and admission to hospice. Further interview with the Administrator and DON at 2 PM on [redacted], revealed the facility did not have a current health assessment reflecting the current health changes and current ADL level for the resident, as required.
Class III

A 052 SS=G	58A-5.0185(3) FAC Medication - Assistance with Self-Admin	A 052		

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(3) ASSISTANCE WITH SELF-ADMINISTRATION.
(a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.
(b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.
(c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.
(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon

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leaving the facility, with this fact noted in the resident ' s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(4) Assistance with self-administration does not include:
(a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications through intermittent positive pressure breathing machines or a
(d) Administration of medications by way of a tube inserted in a cavity of the body.
(e) Administration of preparations.
(f) Irrigations or debriding agents used in the treatment of a skin condition.
(g) , , or preparations.
(h) Medications ordered by the physician or

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health care professional with prescriptive authority to be given " as needed, " unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.
(i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

This Statute or Rule is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that the trained staff (Med Techs) assisted residents with medications in a timely and acceptable time frame for 6 of 6 residents observed during the medication observation pass (Resident # 9, #10, #11, #12, # 13, and #14). Based on observation, interview and record review revealed the facility failed to follow manufactures instructions related to the discarding of [redacted] vials when they expired.

The findings include:
The surveyors entered the building at approximately 8:55 AM. Interview with the Nursing Director at 9:00 AM revealed that Med Techs assist the residents with their medications (meds) on all three shifts (7 AM - 3 PM; 3 PM - 11 PM; & 11 PM - 7 AM). She said the Med Techs pass the medications in the dining [redacted] they were assisting the residents with medications at that time. Observation at 9:05 AM revealed Med Tech#1 was assisting with medications outside the dining [redacted] a counter and Med Tech #2 was in the dining [redacted] residents with medications. Each Med Tech had their own separate medication cart.

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Observation and interview with Med Tech #1 on duty during the day shift of , at approximately 9:05 AM, revealed the residents medications are in single packets with the residents' name, time the medication is to be given, the medication name, dosage and instructions. She said there are also residents who get meds in a labeled bottle from the VA. The Med Techs (#1 and #2) said there are 2 Med Techs on each shift including the night shift. Further interview with the Med Techs following the medication observation passes at approximately 10:30 AM, revealed they were taught that all medications are to be given within one (1) hour before or after the scheduled times. Interview with the Nurse Director/LPN (licensed practical nurse) revealed she agreed the Med Techs are taught to give the medications within an hour before or after the scheduled times and that this is the standard of practice provided in training. Observations during the medication observation pass that started at approximately 9:05 AM revealed:

1. Med Tech #1 prepared 9 oral medications for Resident #9. Review of these medication packets and the Medication Observation Record (MOR) revealed the Med Tech had prepared the ordered 5 AM 125 mcg and the ordered 6 AM 20 mg and gave to the resident at 9:09 AM with the other medications. Six (6) of the other medications 5 mg, 0.125 mg, 50 mg, 5 mg, D 2000 units, 200 mg every 12 hours) were listed on the packet & MOR to be given to the resident at 8 AM. Interview with the Med Tech at this time revealed they were taught to provide the medications an hour before or after the scheduled times. The Med Tech also said Resident #9 is ordered a 5% patch to be put on at 8 AM but she

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would take the resident to her [redacted] apply it later. Review of the MOR revealed the resident was to have the patch applied at 8 AM. At 10:24 AM, the Med Tech came and got the surveyor, took the resident to the resident [redacted] applied the [redacted] patch to the right lower back without donning gloves. The resident did not assist in this application. The Med Tech did not date or initial the patch. Interview again with the Med Tech revealed if she applies a daily patch she does not date or initial it, but only if it's ordered weekly or every so many days. The Med Tech further said there is' no direction as to where to place the patch' but she applied it yesterday so knew it was on the other side of the back; She said if another Med Tech had applied it, she would not know where it had been as it is removed on the evening prior. There was no evidence on the MOR or notes as to where the patch had been applied on the previous day. Further investigation revealed there was in-fact a Licensed Practical Nurse (LPN) on duty.

2. Observation during the same medication observation pass with the same Med Tech revealed she prepared medications for Resident # 10 at 9:15 AM. Review of the MOR revealed the scheduled medication time for these medications was 8:00 AM. These medications included 10 mg daily, [redacted] 20 mg every AM, [redacted] 10 mg twice daily, and [redacted] 20 mg daily.

3. Observation during the same medication observation pass with the same Med Tech revealed she prepared 10 medications for Resident #11 and mixed them whole in chocolate pudding at 9:23 AM. The Med Tech attempted 4 times to assist the resident to take them but the resident refused. Review of the MOR revealed the medications were to be given at 8:00 AM.

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4. Observation during the same medication observation pass with the same Med Tech revealed she prepared medication for Resident #12 at 9:28 AM & gave them to the resident. The medication included: 40 mg daily at 6:30 AM, 10 mg every AM, 10 mg daily, 5 mg daily, SR 100 mg every AM, and 0.5 mg three times a day (8 AM, noon, 5 PM). Review of the MOR revealed the scheduled time for the was 6:30 AM. The other medications were scheduled for 8:00 AM.

5. Observation during another medication observation pass with Med Tech #2 revealed she prepared medication for Resident #13 at 9:35 AM. The medications included MVI daily, 1 mg daily, 20 mg daily, 20 mg twice daily, 10 mg twice daily, 25mg daily and patch. Review of the medication packet & the MOR revealed the scheduled time for the medications to be given was 8:00 AM.

6. Observation during this same medication observation pass with Med Tech #2 revealed she prepared medication for Resident #14 at 9:40 AM. The medications included 20 mg daily, 100 mg daily, 50 mg daily and MVI one daily. Review of the MOR and the packets the medications were in revealed the scheduled time to give was 8:00 AM.

Interview with the Nursing Director at approximately 10:05 AM with the Administrator, present revealed the Med Techs are taught to given the medications within one hour before or after the scheduled times. She agreed with the findings and that the medications were provided

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outside the scheduled time frame (of 2 hours total) and she would fix it. She and the administrator agreed the night med tech should be giving the scheduled medication during the night shift (i.e. the 5 AM, 6 AM and the 6:30 AM scheduled meds).

7. The [redacted] vials were reviewed in the fridge in the medication [redacted] the Med Tech and the Nurse Manager present. Interview with the nurse director at 10:20 AM revealed: once the vials are opened they are good until the expiration date on the bottle.
Observation with the nurse and the Med Tech of the fridge at the nursing station revealed:
a. An [redacted] Lantus vial was labeled as being delivered by pharmacy on [redacted] the vial was opened for use and it was almost empty (approximately 1/4 inch solution left in vial); there was no date or initial on the vial or box as to when it was opened. Review of the manufactures instructions with the [redacted] revealed "In use vial - good for 28 days ... at refrigerated or [redacted]

b. An [redacted] R vial had been opened and dated with a date of [redacted] (date opened). It was partially used. Review of the manufactures instructions in the box with this vial revealed "Throw away an opened vial after 6 weeks (42 days) of use, even if there is [redacted] left in the vial".
Interview with the Med Tech at this time revealed both random residents are still receiving the [redacted]

Class II

A 055 SS=D	58A-5.0185(6) FAC Medication - Storage and Disposal	A 055	

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(6) MEDICATION STORAGE AND DISPOSAL.
(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; 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

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requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by 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;
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
4. Kept separately from the medications of other residents and properly closed or sealed.
(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.
(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).
(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

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to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.
(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.

This Statute or Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure medications were centrally stored for three randomly sampled residents (#21, #22 and #23), evidenced by allowing storage of medications at bedside or in the resident's refrigerator when the residents were assessed as needing assistance with self-administration of medications.

The findings include:

During a tour of the facility conducted at 10:20 AM with the facility's director of nursing (DON)present, the following concerns were noted:

1. In resident , bed A, vials of and a unit were observed on resident #21's nightstand next to her bed. Review of her medical examination (AHCA Form 1823) dated documented she requires assistance with self-administration of medications. A written health care provider order dated called for treatments with this medication twice daily for seven days.

2. In resident , bed B, vials of and a unit were observed on resident #21's nightstand next to her bed. Review of her medical examination (AHCA Form 1823) dated documented she requires

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(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 13	A 055		

assistance with self-administration of medications. A written health care provider order dated called for treatments with this medication twice daily for ten days.

3. In resident bed B, two over-the-counter medications were observed. The resident's refrigerator was noted to contain a bottle of , and a bottle of Murine tears (labeled with instructions to call the poison control center if ingested) was observed on the resident's nightstand next to her bed. Review of her medical examination (AHCA Form 1823) dated documented she requires assistance with self-administration of medications. The medications were not listed on her medication observation records, nor was there any written health care provider orders for these two medications.

In an interview conducted at 1:00 PM, the DON acknowledged these residents required assistance with self-administration of medications and that the medications should have been stored centrally while being used, and when the treatments ended, should have been either stored separately from the residents' active medication supplies for possible future use, or removed from the facility within 30 days after the prescribed treatments ended. She also acknowledged the over-the-counter medications require a written health care provider's order, must be properly labeled, and must be stored centrally. She further acknowledged facility staff should be monitoring resident accordingly.

These concerns were discussed with and acknowledged by the administrator on at 3:00 PM.

Agency for Health Care Administration

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	AL11912046	A. BUILDING _____ B. WING _____	

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A 079 SS=D	58A-5.019(4) FAC Staffing Standards - Levels	A 079		

(4) STAFFING STANDARDS.
(a) Minimum staffing:
1. Facilities shall maintain the following minimum staff hours per week:

Number of Residents	Staff Hours/Week
0-5	168
6-15	212
16-25	253
26-35	294
36-45	335
46-55	375
56-65	416
66-75	457
76-85	498
86-95	539

For every 20 residents over 95 add 42 staff hours per week.
2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night.
4. At least one staff member who is trained in First Aid and as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility.
5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least must be designated in writing to be

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in charge of the facility.
6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement.
7. The administrator or manager ' s time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility ' s staffing schedule.
8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.
(b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C.
(c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident ' s care.
(d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care

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standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents ' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required.

1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs.

2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency.

3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met.

(e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.

(f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively.

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This Statute or Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure resident care standards were met for four selected (#4, #15 and #16) and four randomly observed residents receiving hospice services, evidenced by inadequate staffing available to assist residents who required moderate to complete assistance with eating meals.

The findings include:

Lunch meal observations were conducted in the assisted dining [redacted] beginning at 12:05 PM. There were about 14 residents and 4 caregivers present, one hospice nurse was observed feeding and providing assistance to one resident. Eight of the residents were identified as receiving hospice services and needing moderate to complete assistance with eating meals.

The four caregivers were observed assisting the residents who, this day, mostly needed extensive or complete assistance with eating. They also assisted the other residents present with meal set up, supervision, and any requests or needed accommodations.

The four caregivers were not able to provide a proper dining experience for the hospice residents as they had to move from resident to resident, a third of their time spent standing up while feeding the residents, there was minimal time for verbal exchanges between the caregiver and the resident she was feeding. Insufficient hand washing between residents was also noted.

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Resident #4 was observed at 12:05 PM seated in a gerichair, a reclining wheelchair with an empty lap tray attached to the front which could not be removed by the resident. The residents seated near her were eating. She was observed repeatedly shifting her position in her seat and pulling at the tray. She did not receive her meal until 12:25 PM and did not receive a drink until 12:35 PM.

An associated but independent concern was cited under A092 in this report related to written instructions, staff knowledge of, and use of liquid thickener for resident #16.

These concerns were discussed with and acknowledged by the administrator and the director of nursing on at 3:00 PM.

Class III

A 092 SS=D	58A-5.020(1) FAC Food Service - General Responsibilities	A 092		

Food Service Standards.
(1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall:
(a) Be responsible for total food services and the day to day supervision of food services staff.
(b) Perform his/her duties in a safe and sanitary manner.
(c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets.
(d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C.

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This Statute or Rule is not met as evidenced by:
Based on observations, interviews and record review, the facility failed to ensure food service management staff and dietary staff performed their duties in a safe and sanitary manner and failed to provide proper therapeutic diets, evidenced by rinsing chicken with tap water after a 'boil water order' was issued (this had the potential to affect all residents currently living at the facility) and by not ensuring 1 out of 20 sampled residents (#16) received the proper liquid consistency.

The findings include:

1. During a tour of the kitchen on [redacted] at approximately 10 AM, it was noted that the Food Service Manager and 1 Dietary Staff member were observed washing and cleaning approximately 4 large boxes of chicken in the kitchen sink (two compartment sink). An interview with the Dietary Manager at 10:15 AM on [redacted], revealed the chicken was being clean to be frozen for the meals of the following week.

During observations of the entrance conference area at approximately 10:15 AM on [redacted] there was a sign observed posted on the wall directly behind the Receptionist Desk (posted high for visibility for all). The sign documented the following, "Residents - Margate water is contaminated please don't drink [redacted]. An interview with the Receptionist at 10:17 AM on [redacted], revealed the sign was placed on the wall on the noted morning by unknown staff member and that all residents had received a

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copy in their [illegible]. An interview with the Administrator at 10:30 AM on [illegible] revealed he had posted all the signs throughout the building upon his arrival to the facility on [illegible] around 8 AM. It was also revealed the Dietary Manager was informed of the "Do Not Drink Water Order" on same date. However, there were no signs observed during tour of the kitchen on [illegible].

A second tour of the kitchen with the Administrator at 10:40 AM, the Dietary Manager was observed washing about 3 large boxes of chicken wings in the kitchen sink (two compartment). During an interview with the Dietary Manager at approximately 10:45 AM, it was revealed that he was advised of the "Do Not Drink Water Order" by the Administrator this AM. It was revealed that he had forgotten about the order and had not posted any signs. According to the Dietary Manager, it was revealed none of the residents had consumed any of the water or any products made of the city water. He also confirmed that the chicken observed being cleaned in the morning of , was cleaned with contaminated water.

An interview with the local health department at 11 AM on , confirmed the "Do Not Drink Water Order" on at 3 PM. Further interview with the Administrator and the Dietary Manager revealed neither had contacted the local Health Department regarding specific details regarding the "Do Not Drink Water Order" (including start and stop dates and time). It was revealed by the Administrator that he was informed of the order by a staff member that lived in the area on his way to work on the morning of and responded to the order on noted date. He revealed the facility was not aware of the

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order on [redacted] and was not able to comply due to failure of the local Health Department to notify the facility. Further interview with both parties confirmed that the order had not been handled appropriately to ensure that all staff were made aware and that duties/tasks were performed in conjunction with this order. According to the Administrator no residents or staff had become sick.

2. Resident #16 was observed in the assisted dining [redacted] the lunch meal on [redacted] beginning at 12:05 PM. He received a pureed meal and two drinks, water and a red-colored drink, both appeared thin (regular consistency) to nectar thick in consistency. When asked, the caregiver present stated the drinks contained thickener but maybe not enough, and added thickener to the two drinks and to the resident's bowl of chopped jello. Upon further observation, the water appeared to be honey thick and the red drink pudding thick. The thickener added to the jello hardly dissolved and was visible in the jello, giving it an odd appearance and texture. This was brought to the food service designee's attention at the time, he acknowledged the concerns.

A list posted in the assisted dining [redacted] this resident as requiring a puree diet. It did not disclose if the resident required his liquids to be thickened. The food service designee acknowledged this.

In an interview conducted [redacted] at 3:00 PM, the director of nursing presented the following documentation related to resident #16: his medical examination (AHCA Form 1823) dated [redacted] documented he required a regular diet; a hospice nurse comprehensive assessment form dated [redacted] documented he required thick

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liquids but did not specify to what consistency; a care plan dated , 18 months earlier, signed by a health care provider called for his liquids to be thickened to pudding consistency. She stated based on her assessment of his current condition, he required pudding consistency thickened liquids. She acknowledged the conflicting written instructions and the observation-based concerns identified above.

These concerns were discussed with and acknowledged by the administrator on at 3:10 PM.

Class III

A 160 SS=D 58A-5.024(1) FAC Records - Facility — A 160

Records.
The facility shall maintain the following written records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff.
(1) FACILITY RECORDS. Facility records shall include:
(a) The facility ' s license which shall be displayed in a conspicuous and public place within the facility.
(b) An up-to-date admission and discharge log listing the names of all residents and each resident ' s:
1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure and
2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is , the date of

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Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C.
(c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b).
(d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns.
(e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured.
(f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.;
(g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.;
(h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C.
(i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C.
(j) If the facility advertises that it provides special

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care for persons with [redacted] or related [redacted], a copy of all such facility advertisements as required by Section 429.177, F.S.
(k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C.
(l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate.
(m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years.
(n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years.
(o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years.
(p) Additional facility 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.
(q) The facility ' s resident elopement response policies and procedures.
(r) The facility ' s documented resident elopement response drills.

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This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure all incident reports were fully completed with all required information, for 1 out of 20 sampled residents (#15).

The findings include:

Record review indicated an admission date of [redacted] for Resident #15. Review of the resident's health assessment dated [redacted] documented a medical diagnosis of [redacted] and [redacted]. The health assessment also documented the resident only required assistance with all Activities of Daily Living (ADLs). Review of Resident #15's observation notes revealed that on [redacted] resident was found with a laceration on his left hand by the hospice nurse and sent to ER for treatment. During an interview with the Administrator on [redacted] at 12:30 PM on [redacted], it was revealed the facility completed a detailed incident report of the aforementioned incident. Upon receipt and review of the incident report dated [redacted], it was noted the incident report failed to provide a clear description of the incident and circumstances. The incident report documented under description the following; Hospice nurse noted laceration on hand (left) unknown how injury occurred. It was also noted the report lacked documentation of any witnesses and medical attention provided to the resident. During an interview with the DON and the Administrator at 1 PM on [redacted], it was revealed that neither had inquired further investigation to the nature of the incident with facility's staff to determine the cause or circumstances involving the incident and any

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RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Livewell At Coral Plaza
5850 Margate Blvd.
Margate, FL 33063

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2012 by representatives from 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 after **2012** 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Monica Thurman-Smith

for Arlene Mayo-Davis
Field Office Manager

AMD/ls
Enclosure

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