

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 000	Initial Comments An Assisted Living Facility standard biennial licensure survey was conducted on Magnolia Residence, had licensure deficiencies found at the time of the visit.	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 stage sore 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; 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	A 010			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6900

RJ7Y11

If continuation sheet 1 of 17

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 1 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.	A 010		
	This Statute or Rule is not met as evidenced by:			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 2 Based on record review and interview, it was determined the facility failed to ensure a Health Assessment, AHCA form 1823 was completed on every resident upon significant change and that it is reflective of the resident's current health status and care needs, for 2 out of 4 sampled residents (Resident #1 & #4). The findings include: a) Record review indicated an admission date of _____ for Resident #1. Review of the Health Assessment, AHCA form 1823 dated _____ documented a medical diagnosis of Parkinson's _____ and _____. The Health Assessment also documented that the resident only requires assistance with all Activities of Daily Living (ADLs), except for eating, which was noted as independent. During an interview with the Administrator at 11:30 AM on _____, it was revealed the resident now requires total care with all of her ADLs and that this decline in health recently occurred after admission to hospice. Further record review revealed Resident #1 was admitted/enrolled in Hospice on _____. Further interview with the Administrator, revealed the resident was admitted to hospice for _____ and decline in health. Further record review failed to indicate a current health assessment since the significant health change of the resident. It was revealed by the Administrator that the facility did not have a current health assessment reflecting the current health changes and current ADL levels for the resident. b) Record review indicated an admission date of _____ for Resident #4. Review of Resident #4's Health Assessment, AHCA form 1823 dated _____ documented a medical diagnosis of _____ and _____. Ataxia. The Health Assessment also documented that the resident only requires	A 010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 3 assistance with all Activities of Daily Living (ADLs). During an interview with the Administrator at 12 PM on _____ it was revealed the resident now requires total care with all of her ADLs and that this decline in health had recently occurred. Further record review revealed Resident #4 was admitted/enrolled in Hospice on _____. Further interview with the Administrator, revealed the resident was admitted to hospice for _____. Further record review failed to indicate a current health assessment since the significant health change of the resident. It was revealed by the Administrator that the facility did not have a current health assessment reflecting the current health changes and current ADL levels for the resident. Class III	A 010		
A 025 SS=D	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident 's whereabouts. The resident may travel independently in the community. (d) Contacting the resident 's health care provider and other appropriate party such as the resident 's family, guardian, health care surrogate, or case manager if the resident	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 025	Continued From page 4 exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure care and service were provided, as ordered by a resident's physician, for out 1 out of 4 sampled residents (Resident #1). The finding include: Review of Resident #1's record revealed a physicians order dated _____ from hospice to reposition the resident every two hours and increase fluids. During an interview with the Administrator at 11 AM on _____, it was revealed the facility was not aware of this order and therefore, had not followed the order, as required. Class III	A 025		
A 030 SS=D	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 5 accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (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. (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 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of 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	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 6 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 _____. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 7 other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a _____ with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) 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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 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. (i) 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. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to follow regulatory guidelines for utilization of physical for 2 out of 4 sampled residents (Resident #1 & #4). The findings include: a) During an observation of Resident #1, in her	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 approximately 10 AM on _____ it was noted the resident was in bed with 1/2 side rails in the up position. According to the Administrator, the 1/2 rails are used while the resident is in bed and that the resident is incapable of lifting the rails up or down. Review of Resident #1's record revealed the file did not contain a physicians order for the rails neither did the facility have consent from the legal guardian. During an interview with the Administrator at approximately 1 PM on _____ it was revealed he did not have a physicians order or consent for usage of the side rails for the resident, as required. b) During an observation of Resident #4, in her approximately 10:20 AM on _____ it was noted the resident was in bed with two 1/2 side rails in the up position (located side by side). According to the Administrator, the 1/2 rails are used while the resident is in bed and that the resident is incapable of lifting the rails up or down. Review of Resident #4's record revealed the file did not contain a physicians order for the rails neither did the facility have consent from the legal guardian. During an interview with the Administrator at approximately 1:15 PM on _____ it was revealed he did not have a physicians order or consent for usage of the side rails for the resident, as required. Class III	A 030		
A 081 SS=D	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 10 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. (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: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (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: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and (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: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (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	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 11 handling practices. (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. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. 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 direct care staff members received the required in service-training to perform his/her job duties, for 1 out of 3 sampled employees (Employee #2). The findings include: An interview with the Administrator at 1:30 PM on _____ revealed Employee #2 has been employed with the facility for more than 30 days and provides direct care to the residents. Review of Employee #2's personnel file revealed the record lacked documentation indicating the employee has received the following required in service training: a) Emergency procedures, b). Recognizing and reporting major and adverse incidents c) Resident Rights d) Neglect and e) Elopement training	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 12 Class III	A 081		
A 084 SS=D	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfillment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 084	Continued From page 13 accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____ and nasal dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; and g. Recognize the general signs of adverse reactions to medications and report such reactions. (c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. This Statute or Rule is not met as evidenced by: Based on record review, observation and interview, it was determined the facility failed to ensure that all staff that provide assistance with self-administered medications to residents, received a minimum of 4 hours of initial training,	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 084	Continued From page 14 prior to providing this service, for 1 out of 3 sampled employees (Employee #2). The findings include: An interview with the Administrator at 11 AM on revealed Employee #2 provides assistance to residents with self-administered medications. During observations of the medication pass between the hours of 12:50 PM and 1:30 PM on it was confirmed Employee #2 provides assistance to residents with their self-administered medications. Review of Employee #2's personnel file revealed there was no documentation indicating the employee has received the initial 4 hour assistance with self-administered medication training, by a licensed nurse or a pharmacist. Class III	A 084		
A 090 SS=D	58A-5.0191(11) FAC Training - Do Not Orders (11) TRAINING. (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. (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. (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C.	A 090		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 15 This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure that all staff members received training, for 1 out 3 sampled employees (Employee #2). The findings include: Review of Employee #2's personnel file, revealed there was no documentation indicating the employee received training in the facility's policies and procedures regarding An interview with the Administrator at 2 PM on revealed the employee has not received training in the facility's policy, as of the day of the inspection. The Administrator confirmed the employee has been employed with the facility more than 30 days. Class III	A 090			
A 092 SS=D	58A-5.020(1) FAC Food Service - General Responsibilities 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	A 092			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965962	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351		
(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 092	Continued From page 16 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. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure all therapeutic diets are followed as ordered by the physician, for 1 out of 4 sampled residents (Resident #4). The findings include: Review of Resident #4's record revealed a therapeutic diet order for a pureed diet dated _____ and a "thick it" order dated _____. An interview with the Administrator at 12:23 PM on _____ revealed the facility was not aware of the dietary orders for Resident #4. It was also revealed the resident is served a regular diet meal daily and no thickener was used for the liquids. Resident #4 was observed being provided with total care with eating at approximately 12:57 PM until 1:30 PM on _____. The meal observed, provided to the resident, was 1 bowl of soup and 1 ham and cheese sandwich, 8 oz beverage and 1 cup of canned sliced peaches. An interview with Employee #2 (the aide was observed feeding the resident) at 1 PM on _____ revealed "thick it" was not used and the resident is served regular meals on a daily basis. Class III	A 092		



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Magnolia Residence
4838 NW 93rd Terrace
Sunrise, FL 33351

Dear Administrator:

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

Sincerely,


for Arlene Mayo-Davis
Field Office Manager

AMD/lis
Enclosure

