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
	AL11968235	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT MELBOURNE	3260 N HARBOR CITY BLVD MELBOURNE, FL 32935

(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 AMENDED RELATING TO A0030 _ _ _ _ _ _ _ _ conducted Complaint Inspection CCR#2012012222 at _ _ _ _ at Melbourne located at 3260 N. Harbor City Blvd, Melbourne Florida. 3 of the 4 allegations were substantiated _ _ _ _ at Melbourne had deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or therapy _ _ _ _ required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable disease _ _ _ _ is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health	A 008		

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A 008	Continued From page 1	A 008		

care provider, the individual ' s needs can be met in an assisted living facility; and
8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.

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A 008	Continued From page 2	A 008		

2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving:
a. Extended congregate care (ECC) services in facilities holding an ECC license;
b. Services under community living support plans in facilities holding limited mental health licenses;
c. Medicaid assistive care services; and
d. Medicaid waiver services.
(c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.
(d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule.
(f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a _____ order for residents who do not wish _____ to be administered in the case of

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or

(g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure that the Facility Health Assessment Form (1823) was completely filled out for 1 of 2 sampled residents (#2).

Findings:

Record review for resident #2 on at approximately 1:00 PM revealed a Facility Health Assessment Form (1823) dated Review of the form indicated page 5 was left blank and that the physician failed to indicate on page 4 what type of assistance the resident required with self-administration of medication.

Interview with facility administrator on at approximately 3:50 PM who stated that she will have the Director of Resident Care follow up on the issue of making sure the Facility Health Assessment Forms (1823) are completed

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A 008	Continued From page 4 properly when they are received. Class	A 008		
A 030	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 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	A 030		

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A 030	Continued From page 5 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	A 030		

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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 [illegible] and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at 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 [illegible] his or her spouse if both are residents of the facility.

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(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.

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This Statute or Rule is not met as evidenced by:
Based on record review, adverse incident reports and interviews, the facility failed to provide adequate and appropriate health care free from medical neglect, and did not immediately initiate lifesaving measures including the use of the automated external defibrillator and the performance of for 1 of 4 sampled residents (#3) who was unresponsive and did not have a

Findings:

Resident #3 was an independent resident who did not require assistance with Activities of Daily living and medications, resided in a licensed Assisted Living

Record review for Resident #3 revealed a Resident Health Assessment form (1823) dated with diagnosis that included Early and Further review of the chart revealed that the resident did not have a

Review of a service note revealed the following: 4 PM- "Late at 2:45 PM. Resident in the viva hallway. Resident hit his head and Resident was Resident no [sic], responsive to tactical and verbal stimulation. EMT called administers by nurse and CNA until EMT arrived and they took over. Resident family member called and notified".
Another note on at 5 PM noted "resident

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An adverse incident report-1 day noted on Resident #3 was seen walking down hallway near lobby, front desk staff heard him to floor. Nursing department and 911 called immediately. Nurses initiated and mouth to mouth
EMT's arrived and took over life saving measures. Family called. EMT's took resident to hospital where he was pronounced The time of was approximately 3 PM.

Staff Interviews during the survey revealed the following:

1. Interview with the Licensed Practical Nurse (LPN) on at approximately 11 AM and 1:30 who stated she was coming out of the ladies , when she received a call that a resident had near the front door. She went to the Health Center to get her emergency kit bag. (The health center was located on the opposite side of the building from where the resident was located). As she picked up the emergency kit, she realized the cuff was in the Memory Care Unit.

She went through the health Center Unit to Memory Care unit and got the cuff and came out a different door through the front of the unit. She stated that was normal to go to get the emergency kit when she received a call that a resident had , the kit usually had in it the cuff, thermometer, gloves and mouth barrier, in order to check vital signs. She stated as she was leaving the Health center she received second call to hurry.
The LPN stated it took her approximately 10 minutes to get to the resident because at first she did not realize that he was an emergency, no one told her until the second call came.

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When she arrived, the front desk staff was with resident #3, she observed resident#3 on the floor, she first thought that he was breathing, however as she got closer, she realized he was not breathing.
She radioed for Memory Care Director (the Manager on duty) to get the resident's file because the files were kept in the health Center that was located near the memory care unit, to determine if there was a [illegible] or not. She stated that when the manager on duty arrived with the file, the resident did not have A [illegible] she stated she looked in the emergency kit and there was no mouth barrier at that time, she then sent the direct care staff that was present to get a glove to use as a mouth barrier. After the staff returned with the glove, she stated that she did mouth to mouth and the direct care staff did the chest compression. She explained that she thought it was the facility's policy to determine if the resident had a [illegible] before starting [illegible] because that was the policy in the Nursing Home where she had worked before. She further stated she was aware where the defibrillator was located. She added that she had received training on how to use it.

2. Interview on [illegible] at approximately 10:20 AM, 12:30 PM and 3:30 PM with the direct care staff that was present who stated she heard the call over the radio and went to first floor to assist. When she arrived The LPN was waiting for the manager on duty to get resident #3's chart from the Health Care Center. The LPN told her that there was no mouth barrier in the emergency kit and she went to the memory care unit (located on the opposite side of the building) to get a rubber glove to use. The direct care staff would have reached the [illegible] before entering the Memory care Unit.

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A 030	Continued From page 11 When she returned with the glove they started together. The LPN did mouth to mouth and she did the chest compressions. They continued until the paramedics arrived and took over. She stated that she was aware that the facility's policy was to start regardless if the resident had a or not, however since the nurse was in charge she followed her instructions. 3. Interview on at approximately 11:30 AM with the Memory Care Director who stated she had worked at the facility since She did not know the policy. She was the manager on duty the date of the incident. She heard on the radio that the nurse was called. She responded via the radio that the nurse was on the way because the nurse had just left the memory care unit. They nurse called her to get resident #3's chart. They told her resident #3 had and they needed his chart. They did not tell her why they needed his chart. She went right away with the chart. The nurse looked to see if there was a and then began It was about 30 seconds when they asked her to get the chart. 4. Interview on at approximately 1 PM with the Move in Coordinator who stated she was in her office and heard a loud bang, when she went outside she observed that resident #3 had collapsed. He was on the floor outside of her office with his head against the wall on his side. He was making snoring sounds, making noises she had never heard. She asked the front desk staff what happened. The front desk staff stated that he collapsed. She thought that the front desk staff was on the phone calling the nurse or 911. Resident #3 was still making that sound. She asked the front desk staff where the nurse was and she was told that the nurse was called. She realized that 911 was not called, she ran from	A 030		

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where the resident was to the wellness center and the nurse was coming out. The nurse asked if anyone had called 911 and at that time she made the telephone call. The front desk staff was left with the resident. The LPN checked his pulse another CNA came down right away and the two of them were doing what they needed to do. She stated that the resident had just been dropped off at the front door by his daughter. When the paramedics arrived they took over the

5. Telephone interview on approximately 5 PM with the front desk staff who stated, when she was sitting at the desk she heard a loud noise and looked down the hall and observed the resident on the floor. She called and told the nurse that resident #3 had fallen. I she arrived another staff was with him and she heard him making noises. She remained with the resident while the other staff looked for a nurse. She stated that the nurse arrived and she went back to the front desk.

Review of the facility's DNRO revealed that it noted the following: "Our community reserves the right not to withhold CPR the presentation to us of a DNRO. we may elect to provide CPR call 911 in order that the EMS may make their own independent assessment of the DNRO I the resident's condition. In the event a resident experiences cardiopulmonary trained in CPR, a licensed health care provider present in the community, may not Withhold CPR."

interview with the administrator at approximately 2 PM who stated that she learned about the incident from a former employee who conducted an investigation. She confirmed that it

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A 030	Continued From page 13	A 030		

was company policy that the staff initiates ... regardless of whether the resident had a ... until the paramedics arrived.

The facility staff did not notify the nurse that it was an emergency on the original radio call, they only stated the resident had ... the nurse did not come immediately to check on the resident, she left the ladies ... to the health center and memory care unit before attending to the resident. After arriving she did not immediately initiate ... when she found the resident was not breathing as per the facility policy. After finding out the resident did not have a ..., the staff had to wait for another staff to obtain a glove from the opposite side of the building to use as a mouth barrier before starting ... The LPN stated that when she worked in a nursing home, it was required to find out first whether a resident had a ... before providing ... She further stated that was why she did not immediately initiate the ... She added that she was not sure of the ALF policy. Observation made at approximately 11:00 AM revealed that there was a defibrillator located in the back of the health center. The LPN stated she was aware it was there and she knew how to use. However, she did not use it. Additional interview with facility staff revealed there was no Policy and Procedure for the use of the ...

Review of the ... policy revealed:
...plementation/Action:
Notify the Nurse on Duty, Resident Care Director or designee:
Report vital signs (State specific)
Any injury, describe in detail.
Any change of condition.

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The Director of Resident Care or designee will direct staff to contact 911 or ambulance transport, if necessary. Notify the resident's family, responsible party and physician.

Through the interviews obtained none of the staff mentioned that the vital signs were reported to anyone, nor was the change of condition during the time that the call was sent out telling the staff that the resident had fallen. interviews it was revealed that the Direct Care staff did not call 911. The move in coordinator thought that the front desk staff had called 911. When the nurse asked if 911 was called, the move in coordinator did not know and had to ask the front desk staff who stated she had not called 911 and at that time 911 was called by the move in coordinator. The facility did not follow its fall

The facility staff interviewed all stated that if the residents of the facility had a DNR would be in the front of their charts. They stated that was the only way they would know a person had a DNR interviews with some of the staff revealed that some would check for a DNR to doing CPR some of the staff stated they would give CPR checking for the DNRO. facility staff could not consistently explain the facility's DNR The facility's nurse not knowing the facility's policy regarding DNRO resident #3's DNR at the time he stopped breathing, not knowing whether or not, they should or should not give CPR the resident had a DNRO, to send someone to obtain the mouth barrier from the other side of the building because the emergency kit did not contain all of the equipment needed in the event of an emergency. The staff not informing the nurse that the resident had collapsed and instead stated he had fallen, providing life saving measures

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A 030	Continued From page 15 and CPR ... a direct threat to the health safety and well-being of the resident. The facility which was licensed for 17 or more beds, was required to have on the premises at all times a functioning automated external defibrillator to use in the event of an emergency. After the nurse determined that the resident was not breathing, she did not immediately perform CPR ... their DNRO noted. She did not call for someone to bring the AED. the EMT arrived quickly the facility was responsible for providing lifesaving measures immediately: the facility staff neglected to immediately provide the necessary life saving measures because the nurse had to call for someone to bring her the resident's chart and then she had to send someone to get a mouth barrier before providing CPR. en-route to obtain the mouth barrier the staff had to pass the AED. ... II	A 030		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (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 18 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.	A 052		

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(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 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

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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 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:

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A 052	Continued From page 18 Based on interview the facility failed to ensure when unlicensed staff provided assistance with the self-administration of medications, the staff followed the appropriate procedure at all times. Findings: Through interviews with the unlicensed staff on . . . . it was revealed that Staff A who was an unlicensed staff, would pre-pour the medications (took the medication out of its dispensed, properly labeled container, from where it was stored and placed them in a cup and did not in the presence of the resident read the label, remove a prescribed amount of medication from the container, and close the container). Three of the unlicensed staff stated that they did give the medication to the residents after it was pre-poured by the unlicensed staff. One of the staff stated that she was just asked to give the medication to the resident the past week again and refused. The staff stated that they reported it several times to the Resident Care Director. Interview with Staff A on . . . . . approximately 1 PM who stated that one time she did pre-pour the medication and gave it to a staff to give to the resident because when she was about to give the resident the medication, she received a call to go help another resident and asked a staff to give the resident the medication. Interview with the Resident Care Director who confirmed that the staff had informed her that Staff A was asking them to give the resident's their medication after she pre-poured them. She stated that she had spoken to Staff A about it. Class III	A 052		

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A 078	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (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. (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. (c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C. (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		

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specifically describe the services the staffing agency or contractor will be providing to residents.
(e) For facilities with a licensed capacity of 17 or more residents, the facility shall:
1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and
2. Maintain time sheets for all staff.

This Statute or Rule is not met as evidenced by:
Based on observation record review and interview the facility failed to have a statement from a health care provider, based on an examination conducted within the last six months of hire, that the employee is free from signs or symptoms of a communicable including for 3 of 4 sampled staff (A,B & C).

Findings:

1. Review of personnel record for staff B who was hired on revealed that there is no statement from a health care provider that the employee is free from communicable including

2. Review of the personnel records for Staff C who was hired in of 2012 revealed that there is no statement from a health care provider that the employee is free from communicable There is a statement dated indicating that the employee had a chest x-ray and is free from

Interview with the Facility Administrator at approximately 3:50 PM who stated Staff B was sent home and had the test before leaving the facility. The ARNP for the facility will ensure that the appropriate statements are filled out and will

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A 078	Continued From page 21 be in the files of both Staff B and Staff C by Monday. 3. Personnel record review for Staff D revealed that she was hired on , further record review revealed that the freedom from and communicable statement was dated (3 months after hire). The administrator confirmed that Staff D's freedom from and Communicable statement was not completed within 30 days of employment as required. Class III	A 078		
A 163	429.49 FS Records - Resident, Penalties for Alteration Resident records; penalties for alteration.- (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on Personnel record review and interview the facility falsified an Emergency Status System Provider user account Agreement (ESS) and provided the fraudulent documentation to the agency for one of 4 sampled employees' (D). Finding:	A 163		

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A 163	Continued From page 22 On ... at approximately 10 AM the facility staff was asked to provide the ESS Provider user account Agreement form that was submitted to the agency. The form was provided and reviewed. Personnel record review for staff D (the previous administrator) revealed she was terminated on ... Review of the facility's ESS provider user account Agreement revealed that the section that noted Administrator/CEO had staff D's name typed in and there was line drawn through the name, underneath was a line for the administrators signature, on the line was a signature for Staff D and the date signed was ... (after she was terminated). A telephone call was made to staff D at approximately 12 PM who stated that she had last worked at the facility on ... and she did not return, did not recall signing the form. A copy of the form was provided to her to review via e-mail. Staff D replied via email that the signature on the form was not hers. The administrator stated at approximately 3 PM that she was not aware that Staff D's signature was on the form and she was not working at the facility. Class III	A 163		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012
, 2013 (Amended State Form)

Administrator
At Melbourne
3260 N Harbor City Blvd
Melbourne, FL 32935

Dear Administrator:

Re: CCR #2012012222

This letter reports the findings of a state licensure survey that was conducted on , 2012 by representative(s) 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 after **, 2013,** 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 surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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