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
	AL11967845	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANQUILITY HAVEN, LLC	1346 WILDERNESS LANE TITUSVILLE, FL 32796

(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 Complaint inspection CCR#2012013249 was conducted. The facility had deficiencies found during the visit.	A 000		
A 032	58A-5.0182(8) FAC Resident Care - Elopement Standards (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision. 1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility ' s name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with and related assessed at high risk. 2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident ' s family/caregiver. (b) Facility Resident Elopement Response Policies and Procedures. The facility shall	A 032		

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A 032	Continued From page 1 develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include: 1. An immediate staff search of the facility and premises; 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities; 3. The identification of staff responsible for contacting law enforcement, the resident ' s family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to ensure one of 3 residents (#3), who was at risk of elopement; had identification on their persons that included their name and the facility's name, address, and telephone number. Findings: On . at approximately 9:15 AM caregiver A, stated in house 1346 Wilderness Lane, that there had been no elopements at the facility, but she knew that resident #3 been an elopement risk before she moved to the facility. Observations at approximately 9:30 AM revealed the resident sat in the common area with the other residents and had no identification on her person. On . . . . at approximately 12 PM, caregiver B	A 032		

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A 032	Continued From page 2 stated; in house 1350 Wilderness Lane stated she was not aware of any elopements but knew that resident #3 was at risk. Observations at approximately 1:30 PM noted the resident walked to the front door, she was . The staff redirected her. The resident had no identification on her person. Resident record review at approximately 1:30 PM for resident #1 revealed diagnoses of advanced , per assessment dated . The assessment dated indicated she was . and wondered within the home. Order dated indicated to continue to check daily x 2 weeks and call if SBP equals or greater than 140 consistently. "Please obtain bell/alarm on each doo was observed unlocking front door, back doors and may wonder if not heard". The administrator stated at approximately 3:30 PM that the resident had never eloped from the facility and confirmed she did not have identification on her person. Class III	A 032		
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	A 078		

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A 078	Continued From page 3 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 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 record review and interview the facility failed to ensure that staff was assigned duties consist with their training and education and allowed unlicensed staff to perform duties of a nurse.	A 078		

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A 078	Continued From page 4 1. Resident #1 had diagnoses of advanced per assessment dated . The assessment dated indicated she was and wandered within the home. Prescription dated indicated 0.1 mg one by mouth 9 AM, hold if SBP less than 170. Order dated indicated to continue to check daily x 2 weeks and call us if SBP equals or greater than 140 consistently. Order dated indicated give daily "unless top # bp is fewer than 170". Order dated indicated please check twice daily and keep log;, fax weekly x 3 weeks, if is given please check one hour later and record. Order dated indicated continue as ordered. Please fax log weekly x 2 months. Continued review revealed the facility's unlicensed staff took and monitored the resident's and made judgment as to whether to hold or give the medication. The 2013 Medication Observation Record (MOR) listed 0.1 mg one by mouth 9AM, hold if SBP (top number) is less than 170. The MOR indicated "H" from 1/1 to , and and The measurements were also indicated on the MOR. The medication was marked as given for the other dates. The 2013 MOR listed 0.1 mg one by mouth 9AM, hold if SBP (top number) is less than 170. The MOR indicated "H" on 2/2 to 2/4, 2/6, 2/9, to , to and to medication was marked as given for the other dates. The 2012 MOR listed 0.1 mg one by mouth 9AM, hold if SBP (top number) is less than 170. The MOR indicated "H" on 12/2, 12/6 to 12/7, thru	A 078		

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A 078	Continued From page 5 medication was marked as given for the other dates. The [illegible] 2012 2012 MOR listed [illegible] 0.1 mg one by mouth 9AM, hold if SBP (top number) is less than 170. The MOR indicated "H" from 11/8 thru [illegible] to [illegible] and [illegible] to [illegible]. The [illegible] 2012 [illegible] log indicated the [illegible] was [illegible] on [illegible], on [illegible] the pressure was [illegible] and on [illegible] it was [illegible] but the MOR indicated "H". A note at the bottom of the log indicated "Check [illegible] twice daily, if [illegible] is given, please check [illegible] one hour after , for a total of three times for the day (Staring [illegible] 24th 2012). First [illegible] will be taken sitting and the 2nd should be taken standing. If the SBP (top number) is <170, log N/A for third bp as is not needed. If a third bp is needed to be taken, wait one hour and take bp after [illegible] medication. Third bp is needed when first and second bp is over 170 for the top#, Please fill the charts". The [illegible] 2012 2012 MOR listed [illegible] 0.1 mg one by mouth 9AM, hold if SBP (top number) is less than 170. The MOR had "H" on 10/1 to 10/4, 10/7, [illegible] to [illegible] to [illegible]. Per documentation although all the [illegible] taken was less than 170 the [illegible] was documented given: on [illegible] the bp was [illegible] and the medication was given, on [illegible] bp was [illegible] and medication was given, [illegible] the bp was [illegible] and the medication was given, on [illegible] there was no bp documented and the medication was given, as evident by the staff initials on the MOR. 2. Resident #2 had diagnoses of [illegible], and [illegible] and [illegible], per health assessment dated [illegible]. An order dated [illegible] check glucose (twice daily) [illegible]. Order dated [illegible] check [illegible] sitting, standing daily x 1 week, and fax.	A 078		

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A 078	Continued From page 6 Continued review revealed the 2013 MOR indicated "Please check glucose before breakfast and dinner". The MOR had the staff initials and sugars test results. The staff stated at approximately 2 the resident was and needed assistance with his sugar monitoring. The administrator stated at approximately 4 PM that she was not aware that unlicensed staff could not take to determine if a medication was needed or not and were not allowed to help or do sugar testing. Class III	A 078		
AZ819	408.810(9) FS Minimum Licensure Req - Financial Viability 408.810, F.S. In addition to the licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license. (9) A controlling interest may not withhold from the agency any evidence of financial instability, including, but not limited to, checks returned due to insufficient funds, delinquent accounts, nonpayment of withholding taxes, unpaid utility expenses, nonpayment for essential services, or adverse court action concerning the financial viability of the provider or any other provider licensed under this part that is under the control of the controlling interest. Any person who violates this subsection commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. Each day of continuing violation is a separate offense.	AZ819		

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AZ819	Continued From page 7	AZ819		

This Statute or Rule is not met as evidenced by:
Based on interview and facility records review the facility failed to ensure the Agency was informed of financial instability.

Findings:

On [redacted] at approximately 2 PM, the review of the Brevard Property Appraiser web records indicated the facility administrator was the owner of the following properties: 1346 and 1350 Wilderness Lane Titusville Fl., 3340 Pine Street Cocoa Fl., and 430 Vancouver Ave Cocoa Fl., as assisted living facilities.

The Brevard County Clerk of Courts records indicated the above properties were in foreclosure proceedings. Tranquility Haven LLC 1346 Wilderness Lane Titusville was filed on [redacted]. Tranquility Haven 1350 Wilderness Lane Titusville was filed [redacted] and Tranquility Haven LLC II 430 Vancouver was filed [redacted].

Interview on [redacted] at 10 AM with the administrator/owner; she stated last year she decided to expand Tranquility Haven LLC from 6 to 12 beds. She would use the property next door 1350 Wilderness Lane Titusville Florida for the expansion. The house was left in need of repairs after tenants moved out. She used $20,000.00 to renovate the home. The City of Titusville came and inspected the home and all went well until the inspector noticed that a toilet had been changed, after seeing an empty box. He stated that permit was needed. The administrator/property owner went and obtained the permit. While at the city of Titusville office, she noticed the permit indicated

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AZ819	Continued From page 8 that the home could not be used by anyone but the owner, who changed the toilet. The toilet was changed by her husband and not a licensed plumber. The house would have to remain empty and it did for a year. In the meantime the property on 3340 Pine Street Cocoa, Florida 32926 was in need of renovations as well. She used about $35,000.00 to renovate that home. That property (3340 Pine Street Cocoa, Florida 32926) would be licensed as an ALF as well. The licensure survey was done residents moved in within 60 days. At 430 Vancouver Ave 4 residents who were on hospice within 4 weeks of each other. While the house was vacant and the ALF at 3340 Pine Street Cocoa, Florida awaited residents, she decided to see an attorney, who suggested filing bankruptcy protection, therefore she filed for Chapter 13. Per advice from the attorney, all the properties and including money owed to IRS was included in the Bankruptcy. The mortgage has been paid to a trustee appointed by the court because of restructuring. On at approximately 1:15 PM review of the US Bankruptcy Court, Middle District of Florida Orlando Division- case number 6:12-16471-ABB revealed the administrator /owner and spouse filed Chapter 13 Plan. She was ordered to pay to a Chapter 13 standing trustee PO Box 1103 Memphis Tennessee 38101-1103. The amounts owed were the IRS $14, 221.31, Bank of America for 4013 Vancouver Ave $79, 841.00; the monthly payment of the property was $861.09, Aurora $1999, 199.98 for 1346 Wilderness Lane, monthly payment was $1,708.74, for 1350 Wilderness Lane, she owed $183,000.00 with a monthly payment of $1,708.74. The property at	AZ819		

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AZ819	Continued From page 9	AZ819		

3340 Pine St Cocoa owed $234,346.31 and the monthly payment was $1,898.60. She also owed PNC bank $41,805.90 with a monthly payment of $151.89 for a vacant property at, address not listed. The payments were set as follow the 1st and 2nd months the payment to be sent to the trustee was $7,500.00 each of the two months, thereafter a payment of $7,610.00.

The administrator /owner stated she must make monthly payments to the court appointed trustee by the 6th of the month. She must submit a bank check by US postal service, certified mail.

She stated that she had not reported her court/financial issues to the Agency, as she thought it needed to be reported after the court made a final decision which was expected in April

Telephone call to Area Office 7 and the Agency's Central Office was made at approximately 1 PM and informed of the findings. The facility was placed on financial monitoring.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

17, 2013

Administrator
Tranquility Haven, Llc
1346 Wilderness Lane
Titusville, FL 32796

Dear Administrator:

Re: CCR #2012013249

This letter reports the findings of a state licensure survey that was conducted on , 2013 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

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