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List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0009 - 58a-5.0181(3) Fac - Admissions - Admission Package S-S= A
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0026 - 58a-5.0182(2) Fac - Resident Care - Social & Leisure Activities S-S= D
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0051 - 58a-5.0185(2) Fac - Medication - Pill Organizers S-S= G
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= G
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (otc) Products S-S= D
St - A - 0074 - 58a-5.019(3)(b) - Staffing Standards - Personnel File (bgs) S-S= A
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - / S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0091 - 58a-5.0191(12) Fac - Training - Documentation & Monitoring S-S= A
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments

A standard biennial licensure survey was conducted from through at Southern Breeze Living, LLC. At the time of the survey, deficiencies were identified.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on observation, record review and interview, the assisted living facility failed to ensure 1 out of 2 (resident #1) current residents had an accurate and/or completed Health Assessment {AHCA Form 1823}.

Findings Include:

1) Observations on 09-04-13 at approximately 10:35 AM revealed resident #1 ambulated with the assistance of a walker.

Observations on 09-05-13 at approximately 8:41 AM found staff A assisted resident #1 in getting out of her chair.

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Observations found staff A brought resident #1's walker to her. Observations found resident #1 began to sit without the chair present. Observations found staff B took over to assist resident #1 with getting to her walker. Observations found resident #1 was then able to ambulate with a walker.

2) Record review of resident #1's health assessment, 11-07-12, revealed the following question was left blank and incomplete, "5. Require 24-hour nursing or care?". Record review revealed resident #1's health assessment indicated she was independent with ambulation. Scanned for documentation.

3) In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated the 1823's are "horrible". He stated there are medications on there that they have not taken in months. He stated that they call the physician when they are wrong and they are usually good about it. He stated the issues with the health assessments are not minor cases.

In an interview with the administrator and staff A on 09-05-13 at approximately 10:42 AM, they acknowledged the findings.

Class III

0009-Admissions - Admission Package 58A-5.0181(3) FAC

Based on observation, record review, and interview, the assisted living facility failed to have all of the required information available in their admission packet.

Findings Include:

1) Observations on 09-05-13 at approximately 9:25 AM found the facility did not have an admission packet readily available. Observations found the administration had to put one together upon request.

1) Record review of the facility's admission packet revealed the following components were missing:
- Food service and the ability of the facility to accommodate special diets.
- Social and leisure activities generally offered by the facility.
- A statement of facility rules and regulations that residents must follow {the contract mentioned they are attached to "Exhibit E" but failed to include the attachment}.
- A statement of the facility policy concerning and Advance Directives.
- A copy of the facility's resident elopement policies and procedures.
- A copy of the resident's bill of rights.

**Copy of the admission packet was obtained.

Record review of resident #1, admitted 01-01-13, revealed her Power of Attorney signed and completed all of her paperwork including contract.

Record review of resident #2, admitted 8-29-13, revealed her Power of Attorney signed and completed all of her paperwork including contract.

2) In an interview with resident #1 on 09-04-13 at approximately 10:40 AM, she stated she was not sure if the

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facility ever explained to her her resident rights.

In an interview with resident #2 on 09-04-13 at approximately 10:59 AM, she stated she does not know if the facility gave her her rights. She stated she did not sign a contract when she got there.

In an interview with the administrator on 09-05-13 at approximately 9:32 AM, he stated he would need to make a copy of the health assessment and the contract {components of the admission packet} because he was not sure if he had another copy. He stated he thought those copies were his last copies.

In an interview with the administrator on 09-05-13 at approximately 9:36 AM, he stated that the copy of the admission packet received included everything. He stated he would add to it as needed.

In an interview with the administrator on 09-05-13 at approximately 9:40 AM, he stated he had an elopement policy but he did not include it in the admission packet. He stated the Ombudsman was where you found the resident rights on that form.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, he acknowledged the findings.

Class

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on interview and record review the assisted living facility failed to document recent and injury for 1 out of 2 (resident #1) current residents.

Findings Include:

1) In an interview with staff A on 09-04-13 at approximately 2:46 PM. She stated she took resident #1 to the doctor because of her feet and he prescribed her { } because her feet were very . She stated resident #1 had tripped and about six weeks ago and had to have home health come in and do physical as a result of the . She stated they went and talked to the physician about it. She stated the physician assessed the reason for her .

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated he does not write in the residents' files. He stated he would make copies of third party services observations and "those kind of things". He stated when resident #1 reaches for something, she will . He stated she from her bed and there was and they were concerned about the so he called her daughter.

In an interview with the administrator and staff A on 09-05-13 at approximately 10:42 AM, they acknowledged the findings and the administrator stated that he did not know he needed to maintain documentation of significant changes.

2) Record review of resident #1's file lacked any documentation of a , or any third party services rendered.

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Class III

0026-Resident Care - Social & Leisure Activities 58A-5.0182(2) FAC

Based on observations and interview the assisted living facility failed to have an activities calendar posted. The facility failed to provide and offer activities to the residents.

Findings Include:

1) Observations during the facility tour on 09-04-13 at approximately 10:00 AM found the facility lacked a posted activities calendar.

2) In an interview with resident #2 on 09-04-13 at approximately 10:59 AM, she stated that she had only been living at the facility for a short time. She stated she has not been offered activities since she has been there. She stated it is okay with her that they do not offer activities, but she would do it if they were offered.

In an interview with staff #1 on 09-04-13 at approximately 2:46 PM, when asked if the facility had an activities calendar, she stated she has an activities calendar in her head.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated he does not have an activities calendar. He stated he sits with resident #1 and explains her television shows to her as activities. He stated he does not know what resident #2 likes because she is so new.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged the findings.

Class III

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC

Based on record review and interview, the assisted living facility failed to complete two elopement drills per year. The facility failed to ensure the elopement policy included the minimum components.

Findings Include:

1) Record review of the facility's elopement policy revealed the policy failed to include all required components. Record review revealed the facility's policy failed to address the continued care of all residents in the event of the event. Record review revealed the facility's elopement policy stated "at least two (2) elopement drills per year will be performed by administrator and at least one staff member". Record review lacked any documentation of any elopement drills conducted.

2) In an interview with the administrator on 09-05-13 at approximately 10:21 AM, he stated he was able to find his elopement policy, but could not locate his elopement drills. He stated he had done them, but could not provide documentation.

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In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged the findings.

Class III

0051-Medication - Pill Organizers 58A-5.0185(2) FAC

Based on observation, record review, and interview the assisted living facility failed to ensure a licensed nurse managed a pill organizer for 1 out of 2 (resident #2) current residents. The facility failed to ensure that only residents who self-administer medications utilize a pill organizer.

Findings Include:

1) Observations on 09-04-13 at approximately 9:28 AM found a white plastic container with four pill organizers. Observations found three of the pill organizers had medications in them.

Observations on 09-05-13 at approximately 8:25 AM found staff #1 brought resident #2's pill organizer out from the medication cabinet area. Observations found she brought it into the kitchen. Observations found she was unable to open the pill organizer. Observations found she requested that staff #2 open the pill organizer compartment for her. Observations found she brought the pill organizer to resident #2 who was sitting at the dining waiting for breakfast. Observations found staff #1 stated to resident #2 to not take her medications until after she ate her breakfast and then walked into the kitchen. Observations found the compartment that was opened contained six pills.

Observations on 09-05-13 at approximately 8:37 AM found staff #1 brought over a small plastic cup to resident #2.

Observations on 09-05-13 at approximately 8:50 AM found staff #2 pushed the pill organizer towards resident #2 and stated, "don't forget".

Observations on 09-05-13 at approximately 8:55 AM found staff #1 asked resident #2 if she was ready to do her pills. Observations found after resident #2 responded yes, staff #2 stated, "it is open for you".

Observations on 09-05-13 at approximately 8:57 AM found resident #2 was having trouble getting the medications out of the pill organizer and was unable to get all the medication in the cup. Observations found staff #1 helped her and switched the hands in which she had the pill organizer in. Observations found staff #1 cued resident #2 to pick it up with her right hand and turn over the pill organizer over the cup. Observations found staff #1 assisted resident #2 in getting all of the pills into the plastic cup. Observations found staff #1 then closed the compartment and took the pill organizer away.

2) Record review of resident #2's health assessment {AHCA Form 1823} revealed the physician indicated resident #2 needed help with her medications. Record review revealed the physician did not specify if she needed assistance with self-administration of medication or administration of medication.

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Record review of staff #1's personnel file revealed she completed the initial assistance with self-administration of medication course on 02-21-12 and the continuing education on 12-18-12. However, staff #1 was not a licensed nurse.

Record review of staff #2's personnel file revealed she did not complete any assistance with self-administration of medications courses. However, staff #2 was not a licensed nurse.

Record review revealed the facility did not have a Medication Observation Record {MOR} for resident #2. Record review revealed there were no physician orders for medications. Record review revealed a list of names of medications with resident #2's name on it. Record review revealed there was no way to differentiate each medication.

3) In an interview with the administrator on 09-04-13 at approximately 9:28 AM, he stated resident #2 came a few days ago. He stated she uses a pill organizer and takes it herself. He stated they just make sure that she takes them. He stated her primary caregivers filled the pill organizers. He stated she has been at the facility since the 28th or 29th {of _ }. He stated her primary caregivers are currently on a cruise and he thinks that she will be permanent even when they get back. He stated he did have her sign a resident contract. He stated they are caregivers but are not her family. He stated he or his wife, staff #1, give the medications. He stated he does not use a Medication Observation Record {MOR} for resident #2 because she takes her own medications.

In an interview with resident #1 on 09-04-13 at approximately 10:59 AM, she stated the facility gives her her medications. She stated she gets her medications in a little cup. She stated she used to take her medications herself but she does not anymore. She stated she does not know what medications she takes but someone will pour them in a cup for her.

In an interview with staff #1 on 09-04-13 at approximately 2:46 PM, she stated she does most of the medications. She stated resident #2's pill organizer was filled by her primary caregiver. She stated she gives her the medication from the pill organizer. She stated she does not know which medications were which. She stated it would be better if it wasn ' t in the pill organizer but they gave her a list of what the medications are. She stated she opens the box for resident #2 and takes the container and hands it to her and watches her take it. She stated that is as close as she can get under the circumstances.

In a phone interview with staff #2 on 09-04-13 at approximately 3:45 PM, she stated staff #1 puts the residents' medications in a cup and if she walks away, she will ask her to make sure the residents took their pills after they eat breakfast.

In an interview with staff #1 on 09-05-13 at approximately 8:10 AM, she stated resident #2's medication are in a container and she will open up the lid for her. She stated she does not need assistance and will watch her take it.

In an interview with resident #2 on 09- at approximately 8:28 AM, she stated that the way she received her medication this morning was new to her. She stated she usually gets it in a cup.

In an interview with staff #1 on 09-05-13 at approximately 8:29 AM, staff #1 came out from the kitchen and stated what resident #2 said was not true {in front of resident #2}. She stated that it was inaccurate and she does not leave them for her in a cup. She stated she assists her in getting the pills into the cup because of her hands.

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In an interview with staff #1 on 09-05-13 at approximately 8:59 AM, she stated that she does not know what medications resident #2 just got. She stated she knows she got but she stated she will have to get the list. She stated she thinks she put the in the morning also. She stated she had to look up some of them by picture. She stated that they allowed her to do it by the week because resident #2 could do it on her own.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated he knows that unlicensed staff are not allowed to assist with pill organizers. He stated resident #2 was given a two weeks supply and their role is to open it and they are put in the position to help to the extent of opening the lid and handing it to her. He stated he is not sure the difference between administration of medication and assistance with self-administration of medication.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged the findings and staff #1 confirmed she assisted with the pill organizer and she is not a licensed nurse. She stated neither is the administrator.

Class II

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation, record review, and interview the assisted living facility failed to provide assistance with self-administration of medication per the guidelines as noted in 429.256, F.S. The facility failed to ensure qualified staff provide assistance with self-administration of medications, failed to ensure qualified staff observe residents taking medications, and failed to ensure the label was read in the presence of the resident for 2 out of 2 (resident #1, resident #2) current residents.

Findings Include:

1) Observations on 09-04-13 at approximately 1:03 PM, found staff #1 asked resident #2 if she puts on her patch herself. Observations found resident #2 answered "no staff #2 helps".

Observations on 09-04-13 at approximately 1:25 PM found patches in a plastic bag located near the sink in one of the designated for resident use.

Observations on 09-05-13 at approximately 8:25 AM found staff #1 brought a pill organizer to resident #2 who was sitting at the dining waiting for breakfast. Observations found staff #1 stated to resident #2 to not take her medications until after she ate her breakfast and then walked into the kitchen. Observations found the compartment that was opened contained six pills. Observations found staff #1 never read the label in the presence of the resident.

Observations on 09-05-13 at approximately 8:50 AM found staff #2 pushed the pill organizer towards resident #2 and stated, "don't forget".

2) Record review of resident #2's health assessment (AHCA Form 1823) revealed the physician indicated resident #2 needed help with her medications. Record review revealed the physician did not specify if she needed assistance with self-administration of medication or administration of medication.

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Record review of staff #1's personnel file revealed she completed the initial assistance with self-administration of medication course on 02-21-12 and the continuing education on 12-18-12. Record review revealed staff #1 was not a licensed nurse.

Record review of staff #2's personnel file revealed she did not complete any assistance with self-administration of medications courses. However, staff #2 was not a licensed nurse.

3) In an interview with resident #2 on 09-04-13 at approximately 10:59 AM, she stated staff #2 puts her patch on her back. She stated she puts it on every day. She stated staff #1 will put the patch on her when staff #2 doesn't. She stated her medications are given to her in a little cup. She stated she used to take them herself but she doesn't anymore. She stated she does not know the medications she takes. She stated someone just pours them into a cup.

In a phone interview with staff #2 on 09-04-13 at approximately 2:46 PM, she stated she assisted resident #2 this morning with her patch. She stated staff #2 had a and sometimes she has trouble putting the patch on her back. She stated she will make sure that the residents take their medications after breakfast that staff #1 leaves for them.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated he is not sure the difference between administration of medication and assistance with self-administration of medication and asked for clarification.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:43 AM, they acknowledged the findings and the administrator confirmed that staff #2 assists resident #2 with her patch.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC

Based on observation, record review, and interview the assisted living facility failed to ensure 1 out of 2 (resident #1) current residents who required administration of medication received medication from a staff member who was licensed to administer medications.

Findings Include:

1) Observations on 09-04-13 at approximately 9:40 AM found the administrator brought out a plastic bin with all of resident #1's medications.

Observations on 09-05-13 at approximately 7:59 AM found resident #1's medication in a plastic bin near the facility's medication cabinet {unsecured}.

2) Record review of resident #1's health assessment {AHCA Form 1823}, dated 11-07-12, revealed resident #1 required administration of medication.

Record review of resident #1's medication observation record {MOR} revealed staff #1 and the administration

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initialed the MOR indicating they provided resident #1 with her medications.

Record review of staff #1's personnel file revealed she completed the initial assistance with self-administration of medication course on 02-21-12 and the continuing education on 12-18-12. Record review revealed staff #1 was not a licensed nurse.

Record review of the administrator's personnel file revealed he completed the initial assistance with self-administration of medication course on 02-22-12 and the continuing education on 12-18-12. Record review revealed staff #1 was not a licensed nurse.

3) In an interview with the administrator on 09-04-13 at approximately 9:40 AM, he stated he and his wife gave out the medications in the facility. He stated the MOR without a name belonged to resident #1. He stated he was unsure if resident #1 received her medications this morning. After clarification from staff #1, he stated resident #1 received her medications this morning.

In an interview with the administrator on 09-04-13 at approximately 12:15 PM, he stated staff #1 primarily gives out the medications, but he will do it too. He stated neither he, nor staff #1 was a nurse.

In an interview with staff #1 on 09-05-13 at approximately 7:50 AM, she stated she had already given resident #1 her medications this morning.

In an interview with staff #1 on 09-05-13 at approximately 8:10 AM, she stated she gives resident #1 about four pills at a time. She stated she puts it in a cup for her. She stated she watches her take her medications.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated resident #1 needs medication administration and they do medication administration for her. He stated he is not positive of the difference between assistance with self-administration of medication and medication administration. After the difference was explained, he stated he did not know that resident #1's health assessment stated she needed medication administration. and that they are only supposed to do assistance with medications. He stated "you tell me what I need to do".

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged the findings and staff #1 confirmed she was not a licensed nurse and stated neither was the administrator.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on observation, record review, and interview, the assisted living facility failed to ensure that a medication observation record {MOR} was properly maintained for 2 out of 2 {resident #1, resident #2} current residents who receives assistance with self-administration of medication. The facility failed to have ensure the residents' MOR had all the necessary components for 1 out of 2 (resident #1) current residents. The facility failed ensure a resident who used a pill organizer had the proper documentation of medications for 1 out of 2 (resident #2) current residents.

Findings Include:

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1) Observations on 09-04-13 at approximately 9:40 AM found the administrator brought out a plastic bin which contained all of resident #1's medications.

Observations on 09-05-13 at approximately 8:25 AM found staff #1 brought resident #2's pill organizer out from the medication cabinet area. Observations found she brought it into the kitchen. Observations found she was unable to open the pill organizer. Observations found she requested that staff #2 open the pill organizer compartment for her. Observations found she brought the pill organizer to resident #2 who was sitting at the dining waiting for breakfast. Observations found staff #1 stated to resident #2 to not take her medications until after she ate her breakfast and then walked into the kitchen. Observations found the compartment that was opened contained six pills.

Observations on 09-05-13 at approximately 7:59 AM found resident #1's medication in a plastic bin near the facility's medication cabinet {unsecured}.

Observations on 09-05-13 at approximately 8:37 AM found staff #1 brought over a small plastic cup to resident #2.

Observations on 09-05-13 at approximately 8:50 AM found staff #2 pushed the pill organizer towards resident #2 and stated, "don't forget".

Observations on 09-05-13 at approximately 8:55 AM found staff #1 asked resident #2 if she was ready to do her pills. Observations found after resident #2 responded yes, staff #2 stated, "it is open for you".

Observations on 09-05-13 at approximately 8:57 AM found resident #2 was having trouble getting the medications out of the pill organizer and was unable to get all the medication in the cup. Observations found staff #1 helped her and switched the hands in which she had the pill organizer in. Observations found staff #1 cued resident #2 to pick it up with her right hand and turn over the pill organizer over the cup. Observations found staff #1 assisted resident #2 in getting all of the pills into the plastic cup. Observations found staff #1 then closed the compartment and took the pill organizer away.

2) Record review on 09-04-13 at approximately 9:30 AM found resident #1's MOR. Record review revealed resident #1's MOR was not initialed for 09-03-13 and the morning of 09-04-13. Record review revealed resident #1's MOR was whited out and written over the information. Record review revealed resident #1's MOR did not contain the following information: resident #1's name, resident #1's health care provider name and telephone number, strength, and complete directions for use. Record review revealed resident #1's MOR was not updated immediately each time medication was offered.

Record review on 09-05-13 at approximately 8:05 AM found resident #1's MOR. Record review revealed resident #1's MOR was not initialed for having had received her morning medications for 09-05-13. Record review revealed resident #1's MOR was now initialed for 09-03-13 and 09-04-13. Record review revealed resident #1's MOR still did not contain the following information: resident #1's name, resident #1's health care provider name and telephone number, strength, and complete directions for use.

Record review revealed the facility did not have a Medication Observation Record {MOR} for resident #2. Record review revealed there were no physician orders for medications. Record review revealed a list of names of

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medications with resident #2's name on it. Record review revealed there was no way to differentiate each medication.

Record review of resident #2's health assessment {AHCA Form 1823} revealed the physician indicated resident #2 needed help with her medications. Record review revealed the physician did not specify if she needed assistance with self-administration of medication or administration of medication.

Record review of resident #1's health assessment {AHCA Form 1823}, dated 11-07-12, revealed resident #1 required administration of medication.

Record review of staff #1's personnel file revealed she completed the initial assistance with self-administration of medication course on 02-21-12 and the continuing education on 12-18-12. Record review revealed staff #1 was not a licensed nurse.

Record review of staff #2's personnel file revealed she had not completed any assistance with self-administration of medications courses. Record review revealed staff #2 was not a licensed nurse.

3) In an interview with the administrator on 09-04-13 at approximately 9:28 AM, he stated resident #2 came a few days ago. He stated he or his wife, staff #1, gave the medications. He stated he did not use a Medication Observation Record {MOR} for resident #2 because she takes her own medications

In an interview with the administrator on 09-04-13 at approximately 9:30 AM, he stated he was not sure if staff #1 gave the residents their medications this morning yet because she just left. He stated he will have to go check. He stated either he or staff #1 give out the medications to the residents. He stated the MOR {without a name} was for resident #1.

In an interview with the administrator on 09-04-13 at approximately 9:43 AM, he stated resident #1 received her medication this morning {after clarification from staff #1}. He stated he was disappointed that it was not written down. He explained what his initials and staff #1's initials looked like. He confirmed that they do not have a MOR for resident #2 and there was no names to identify resident #2's medications in the pill organizer.

In an interview with staff #1 on 09-05-13 at approximately 7:50 AM, she stated she gave resident #1 her medications about ten minutes ago.

In an interview with staff #1 on 09-05-13 at approximately 8:10 AM, she stated she signed resident #1's MOR this morning but mistakenly signed for Wednesday {09-04-13} instead of Thursday {09-05-13}.

In an interview with staff #1 on 09-05-13 at approximately 8:11 AM, she stated the administrator did not realize he had started the MOR for resident #1 on their original sheet and inquired if they should Xerox the MOR sheet and start over again.

In an interview with the administrator on 09-05-13 at approximately 8:15 AM, he readily confirmed resident #1's MOR was a problem.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated resident #1's MOR is "all screwed up". He stated staff #1 screwed up and did not fill it in correctly. He stated he probably knew the requirements of a MOR but he does not anymore. He stated he had a copy of different copies of the same form.

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He stated the there was he took the one to make copies that had some white out on it so they just changed the MOR. He confirmed he had three copies of the same MOR. He stated is not not sure the difference between administration of medication and assistance with self-administration of medication and requested clarification.

Class II

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observation, record review, and interview, the assisted living facility failed to ensure prescribed medications and over the counter (OTC) products were secured at all times.

Findings Include:

1) Observations on 09-04-13 at approximately 10:00 AM found a door near the dining which read employees only. Observations found the door was unlocked. Observations found the facility's medication cabinet in the . Observations found the key to the cabinet was located in the lock.

Observations on 09-04-13 at approximately 10:17 AM found the following unlabeled OTC medications on the kitchen counter: Root, Cognitex Basics, (B-3 Caps, Resveratrol 100 mg {milligram}, Alpha 100 mg. Observations found the kitchen area was accessible to all staff, residents, and visitors.

Observations on 09-04-13 at approximately 1:25 PM found excelon patches in a plastic bag located near the sink in one of the designated for resident use.

Observations on 09-05-13 at approximately 7:59 AM found resident #1's medication in a plastic bin near the facility's medication cabinet. Observations found the door to the medications were in was open. Observations found resident #1's medications were unsecured and sitting on the counter in the .

2) Record review of resident #2's health assessment {AHCA Form 1823} revealed the physician indicated resident #2 needed help with her medications. Record review revealed the physician did not specify if she needed assistance with self-administration of medication or administration of medication.

Record review of resident #1's health assessment {AHCA Form 1823}, dated 11-07-12, revealed resident #1 required administration of medication.

3) In an interview with the administrator on 09-04-13 at approximately 9:28 AM, he stated he currently has two residents living at the facility.

In an interview with the administrator on 09-04-13 at approximately 10:18 AM, he stated the OTC medications on the kitchen counter belonged to his staff #1. He stated that she was going through it {staff #1 was not currently at the facility at the time}. He inquired if it was an issue and stated he did not believe that those rules applied to his facility because of the size.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged the findings.

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Class III

0056-Medication - Labeling and Orders 58A-5.0185(6) FAC

Based on observation, record review, and interview, the assisted living facility failed to ensure all prescription medications were properly labeled and dispensed prior to the facility providing assistance with self-administration of medication.

Findings Include:

1) Observations on 09-04-13 at approximately 9:28 AM found a white plastic container with four pill organizers. Observations found three of the pill organizers had medications in them.

Observations on 09-05-13 at approximately 8:25 AM found staff #1 brought resident #2's pill organizer out from the medication cabinet area. Observations found she brought it into the kitchen. Observations found she was unable to open the pill organizer. Observations found she requested that staff #2 open the pill organizer compartment for her. Observations found she brought the pill organizer to resident #2 who was sitting at the dining waiting for breakfast. Observations found staff #1 stated to resident #2 to not take her medications until after she ate her breakfast and then walked into the kitchen. Observations found the compartment that was opened contained six pills.

Observations on 09-05-13 at approximately 8:37 AM found staff #1 brought over a small plastic cup to resident #2.

Observations on 09-05-13 at approximately 8:50 AM found staff #2 pushed the pill organizer towards resident #2 and stated, "don't forget".

Observations on 09-05-13 at approximately 8:55 AM found staff #1 asked resident #2 if she was ready to do her pills. Observations found after resident #2 responded yes, staff #2 stated, "it is open for you".

Observations on 09-05-13 at approximately 8:57 AM found resident #2 was having trouble getting the medications out of the pill organizer and was unable to get all the medication in the cup. Observations found staff #1 helped her and switched the hands in which she had the pill organizer in. Observations found staff #1 cued resident #2 to pick it up with her right hand and turn over the pill organizer over the cup. Observations found staff #1 assisted resident #2 in getting all of the pills into the plastic cup. Observations found staff #1 then closed the compartment and took the pill organizer away.

2) Record review revealed there were no physician orders for medications for resident #2. Record review revealed a list of names of medications with resident #2's name on it. Record review revealed there was no way to differentiate each medication due to the lack of documentation {and the medication in a pill organizer}.

Record review of resident #2's health assessment {AHCA Form 1823} revealed the physician indicated resident #2 needed help with her medications. Record review revealed the physician did not specify if she needed

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assistance with self-administration of medication or administration of medication.

3) In an interview with the administrator on 09-04-13 at approximately 9:28 AM, he stated resident #2 came a few days ago. He stated her primary caregivers filled the pill organizers. He stated she has been at the facility since the 28th or 29th {of }. He stated her primary caregivers are currently on a cruise. He stated they are caregivers but are not her family. He stated he or his wife, staff #1, give the medications.

In an interview with resident #1 on 09-04-13 at approximately 10:59 AM, she stated the facility gives her her medications. She stated she does not know what medications she takes, but someone will pour them in a cup for her.

In an interview with staff #1 on 09-04-13 at approximately 2:46 PM, she stated she does most of the medications. She stated resident #2's pill organizer was filled by her primary caregiver. She stated she gives her the medication from the pill organizer. She stated she does not know which medications were which. She stated it would be better if it wasn ' t in the pill organizer but they gave her a list of what the medications are. She stated she opens the box for resident #2 and takes the container and hands it to her and watches her take it. She stated that is as close as she can get under the circumstances.

In an interview with staff #1 on 09-05-13 at approximately 8:59 AM, she stated that she does not know what medications resident #2 just got. She stated she knows she got but she stated she will have to get the list. She stated she thinks she put the in the morning also. She stated she had to look up some of them by picture.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated he did not know the facility was supposed to have physician orders for residents.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged the findings.

Class III

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC

Based on observation and interview the assisted living facility failed to ensure all Over the Counter (OTC) Products were properly labeled as required by 58A-0185(8)(b).

Findings Include:

1) Observations on 09-04-13 at approximately 9:48 AM found the following OTC medications located in a bin designed for resident #1: 100 caplets, Iron 65 mg {milligrams; 2 bottles}, 500 mg, Woman ' s Stimulant 5 mg. Observations found each bottle did not have resident #1's name on them and was not properly labeled.

Observations on 09-04-13 at approximately 10:17 AM found the following unlabeled OTC medications on the kitchen counter: Root, Cognitex Basics, (B-3 Caps, Resveratrol 100 mg {milligram}, Alpha

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100 mg. Observations found none of the bottles were properly labeled.

2) In an interview with the administrator on 09-04-13 at approximately 9:49 AM, he stated resident #1 takes all the OTC medications in the same bin as her medications.

In an interview with the administrator on 09-04-13 at approximately 12:15 PM, he stated resident #1 is not very competent, but she was not been declared not in competent.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged the findings.

Class III

0074-Staffing Standards - Personnel File (BGS) 58A-5.019(3)(b)

Based on observation, record review, and interview the assisted living facility failed to ensure 2 out of 3 (administrator, staff #1) current staff members had the results of employee background screening in their respective personnel files.

Findings Include:

1) Observations on 09-04-13 at approximately 9:28 AM found the administrator at the facility upon entrance.

Observations on 09-05-13 at approximately 7:50 AM found the administrator and staff #1 at the facility upon entrance.

2) Record review of the administrator's personnel file revealed his application was dated 10-28-11. Record review revealed his personnel file lacked background screening results.

Record review of staff #1's personnel file revealed an application that was not dated. Record review revealed her personnel file lacked background screening results.

3) In an interview with the administrator on 09-04-13 at approximately 2:33 PM, he stated he and staff #1 has been working at the facility since it opened but could not remember the date.

In an interview with the administrator on 09-04-13 at approximately 3:10 PM, he stated he was unable to locate verification of the background screening results. He stated he is going to have to call up the Agency and find out how to get it on the website.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated staff #1 and himself at at the facility 24 hours.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged the findings.

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Class

0077-Staffing Standards - Administrators 58A-5.019(1) FAC

Based on record review and interview, the administrator failed to be responsible for the operation and maintenance of the facility and the provision of adequate care to all residents and failed to provide evidence of having a high school diploma or general equivalency diploma.

Findings Include:

1) Record review of the administrator's personnel record revealed his application was dated 10-28-11. Record review revealed the administrator lacked any evidence of having a high school diploma or a general equivalency diploma.

Record review revealed the facility did not conduct elopement drills. Record review revealed the facility did not have an admission and discharge log. Record review revealed the facility did not follow a menu completed by a registered dietitian. Record review revealed an unlicensed staff was assisting with a pill organizer. Record review revealed the facility did not have a staffing schedule. Record review revealed the facility did not have any appointment paperwork in resident #1 or resident #2's file. Record review revealed resident #2 needed a therapeutic diet.

2) In an interview with the administrator on 09-04-13 at approximately 9:28 AM, he stated his current census was two residents.

In an interview with the administrator on 09-04-13 at approximately 9:40 AM, he stated he and his wife gave out the medications in the facility. He stated the Medication Observation Record {MOR} without a name belonged to resident #1. He stated he was unsure if resident #1 received her medications that morning.

In an interview with the administrator on 09-04-13 at approximately 10:07 AM, he identified the 3-day supply of non perishable foods. When asked if there was any other foods for the 3-day supply, he stated the food in the freezer could be used in case of an emergency. He stated that food is used on an every day basis. He stated he does not have a menu for an emergency. He stated he would serve sandwiches and thing the residents eat daily and pull out of inventory.

In a interview with the administrator on 09-04-13 at approximately 10:10 AM, he stated that they do not post a menu. He stated he did not realize until recently that they needed one. He stated that they just got one. He stated that they have it but they have "not implemented as such". He stated if it were implemented it would not be used due to the residents have specific eating habits.

In an interview with the administrator on 09-04-13 at approximately 10:18 AM, he stated the OTC medications on the kitchen counter belonged to his staff #1. He stated that she was going through it {staff #1 was not currently at the facility at the time}. He inquired if it was an issue and stated he did not believe that those rules applied to his facility because of the size.

In an interview with the administrator on 09-04-13 at approximately 2:33 PM, he stated he provided the training's

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to staff #2. He stated he did not follow a curriculum but provided hands on training. He stated he bought staff #2 to the kitchen and went through hand washing and instructed her how to check the temperature of the refrigerator.

In an interview with the administrator on 09-04-13 at approximately 3:10 PM, he stated he was unable to locate verification of the background screening results. He stated he is going to have to call up the Agency and find out how to get it on the website.

In an interview with the administrator on 09-04-13 at approximately 3:16 PM, he stated he was not aware of the requirements for the documentation of the trainings. He inquired if he should make certificates for all of the trainings he did.

In an interview with the administrator on 09-05-13 at approximately 8:15 AM, he readily confirmed resident #1's MOR was a problem.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated the 1823's are "horrible".

In an interview with the administrator on 09-05-13 at approximately 9:32 AM, he stated he was unable to find his college degree or high school diploma. He stated he got it years ago in California. He stated he thinks it is ridiculous that he needs to show proof. He stated he will ask request from his college for a copy of his degree. He also stated he would need to make a copy of the health assessment and the contract {components of the admission packet} because he is not sure if he has another copy.

In an interview, with the administrator on 09-05-13 at approximately 9:37 AM, he stated he does not write in the residents files. He stated he would make copies of third party services observations and "those kind of things". He stated he does not have an activities calendar. He stated he sits with resident #1 and explains her television shows to her as activities. He stated he is not sure the difference between administration of medication and assistance with self-administration of medication and asked for clarification. After the differences was explained, he stated he did not know that resident #1's health assessment stated she needed medication administration,and that they are only supposed to do assistance with medications. He stated "you tell me what I need to do". He stated staff #1 and he wathere 24 hours but he does not have a staffing schedule. He stated he just found out a couple of months ago that he needed a certified menu. He stated it is available to use. He stated resident #1 and resident #2 are not on any special diets. He stated he knew he was supposed to have an emergency supply of food. He stated he does not have a contracted menu for emergency. He stated they may be missing some things. He stated he did not know he needed an admission and discharge log. He stated he has a log near the front door that they use {visitor log}. He stated he did not know each resident needed to have the power of attorney appointments in their files.
He stated he was able to find his elopement policy but cannot locate his elopement drills. He stated he knows a grievance is when you have a "bitch" and have to resolve it.

In an interview with the administrator and staff A on 09-05-13 at approximately 10:42 AM, they acknowledged the findings and the administrator stated that he did not know he needed to maintain documentation of significant changes. He stated he was unable to locate a communicable statement for staff #2. He confirmed that staff #2 did not complete all the necessary trainings within 30 days of employment. He confirmed that not one staff member at the facility completed trainings related to { } and { }. He confirmed that not one staff member at the facility completed trainings related to { }. He confirmed that staff #2's training certificates did not meet the

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minimum criteria.

Class II

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on observation, record review, and interview the assisted living facility failed to ensure 1 out of 3 (staff #2) current facility employees had verification of freedom from communicable .

Findings Include:

1) Observations on 09-05-13 at approximately 8:20 AM found staff #2 in the kitchen preparing breakfast for the residents.

Observations on 09-05-13 at approximately 8:41 AM found staff #2 assisting resident #1 with ambulation.

2) Record review of staff #2's personnel record revealed her application was dated 09-23-12. Record review revealed staff #2 lacked a freedom from communicable statement from a health care provider.

3) In an interview with staff #1 on 09-04-13 at approximately 11:25 AM, she stated staff #2 comes in and bathes the residents. She stated she does all the food prep and cooks and heats up the food.

In a phone interview with staff #2 on 09-04-13 at approximately 3:45 PM, she stated she has been working at the facility for a couple of months. She stated she comes to the facility in the morning to assist with showers and dresses the residents for staff #1.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, the administrator confirmed that he was unable to locate a freedom from communicable statement for staff #2.

Class III

0079-Staffing Standards - Levels 58A-5.019(4) FAC

Based on record review and interview the assisted living facility failed to maintain a written work schedule to reflect its 24-hour staffing pattern for a given time period.

Findings Include:

1) Record review revealed the facility did not have a staffing schedule for 2013. Record review revealed the facility did not have any documentation that they ever used a staffing schedule.

2) In an interview with the administrator on 09-04-13 at approximately 10:30 AM, he stated the facility used to have a staffing calendar but he did not know where it was. He stated staff #2 knows her schedule.

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In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated staff #1 and he is there 24 hours but he does not have a staffing schedule.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, the administrator confirmed that the facility did not have a staffing schedule.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on observation, record review, and interview, the facility failed to ensure that 1 out of 3 (staff #2) current staff members had the required in-service training within 30 days of employment.

Findings Include:

1) Observations on 09-05-13 at approximately 8:41 AM found staff #2 assisting resident #1 with ambulation.

2) Record review of staff #2's personnel record revealed her application was 09-23-12. Record review revealed staff #2 lacked the following required in-service trainings: activities of daily living {ADL} and behavioral needs and elopement training.

3) In an interview with the administrator on 09-04-13 at approximately 2:33 PM, he stated staff #2 has been working at the facility since the first of the year. He stated she is part time and primarily assists the residents with bathing.

In an interview with staff #1 on 09-04-13 at approximately 11:25 AM, she stated staff #2 comes in to bathe the residents.

In a phone interview with staff #2 on 09-04-13 at approximately 3:45 PM, she stated she has been working at the facility for a couple of months. She stated she comes to the facility in the morning to assist with showers and dresses the residents for staff #1.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they acknowledged that staff #2 did not complete all the necessary in-service trainings.

Class III

0082-Training - / 58A-5.0191(3) FAC

Based on observation, record review, and interview the assisted living facility failed to ensure that 3 out of 3 (administrator, staff #1, staff #2) current staff members have the required ( ) and ( ) training within 30 days of employment.

Findings Include:

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1) Observations on 09-05-13 at approximately 7:50 AM found the administrator, staff #1, and staff #2 at the facility upon entrance. Observations found all three staff provided direct care to both residents.

2) Record review of the administrator's personnel file revealed his application was dated 10-28-11. Record review revealed the administrator lacked documentation of completing the educational course on and .

Record review of staff #1's personnel file revealed her application was not dated. Record review revealed staff #1 lacked documentation of completing the educational course on and .

Record review of staff #2's personnel file revealed her application was dated 09-23-12. Record review revealed staff #2 lacked documentation of completing the educational course on and .

3) In an interview with the administrator on 09-04-13 at approximately 2:33 PM, he stated staff #2 has been working at the facility since the first of the year. He stated he and staff #1 had been working at the facility since it opened but could not remember the date.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they confirmed that they had not received specific training related to and .

Class III

0090-Training - **58A-5.0191(11) FAC**

Based on observation, record review, and interview, the assisted living facility failed to ensure that 3 out of 3 (administrator, staff #1, staff #2) current staff members have the required ( ) training within 30 days of employment.

Findings Include:

1) Observations on 09-05-13 at approximately 7:50 AM found the administrator, staff #1, and staff #2 at the facility upon entrance. Observations found all three staff provided direct care to both residents.

2) Record review of the administrator's personnel file revealed his application was dated 10-28-11. Record review revealed the administrator lacked documentation of completing the educational course on 's.

Record review of staff #1's personnel file revealed her application was not dated. Record review revealed staff #1 lacked documentation of completing the educational course on 's.

Record review of staff #2's personnel file revealed her application was dated 09-23-12. Record review revealed staff #2 lacked documentation of completing the educational course on 's.

3) In an interview with the administrator on 09-04-13 at approximately 2:33 PM, he stated staff #2 had been working at the facility since the first of the year. He stated he and staff #1 had been working at the facility since it opened but could not remember the date. He stated he did not believe he has completed a course specifically for 's.

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In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they confirmed that they had not received specific training related to 's.

Class III

0091-Training - Documentation & Monitoring 58A-5.0191(12) FAC

Based on record review and interview, the assisted living facility failed to ensure that the documentation of staff trainings met the minimum requirements for 1 out of 3 (staff #2) current staff members. The facility failed to provide completed training certificates and failed to ensure the following information was included: the location of the training program, the training provider's name including credentials and/or professional license number.

Findings Include:

1) Record review of staff #2's personnel file revealed her application was dated 09-23-12. Record review revealed a document which reflected staff #2 completed the following trainings: control, major incidents, resident rights, reporting neglect and , and nutrition and food services. Record review revealed the name and credentials of the trainer was not documented as per requirement. Record review reviewed the location of the training program was not included.

2) In an interview with the administrator on 09-04-13 at approximately 2:33 PM, he stated he provided the trainings to staff #2. He stated he did not follow a curriculum but provided hands on training. He stated he bought staff #2 to the kitchen and went through hand washing and instructed her how to check the temperature of the refrigerator.

In an interview with the administrator on 09-04-13 at approximately 3:16 PM, he stated he was not aware of the requirements for the documentation of the trainings. He inquired if he should make certificates for all of the trainings he did.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they confirmed that staff #2 did not have the proper documentation for her trainings completed by the administrator.

Class

0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on observation, record review, and interview, the assisted living facility failed to ensure dietary standards were met. The facility failed to ensure the facility menu was followed at all times. The facility failed to ensure the facility menu was posted at all times. The facility failed to ensure adequate substitutions were made. The facility failed to ensure therapeutic menus were available as needed. The facility failed to ensure non perishable foods be on hand at all times that were designated for a 3-day emergency supply. The facility failed to ensure menus were kept on file in the facility for 6 months.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968150	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Southern Breeze Living Llc	18 Woodward Ln Palm Coast, FL 32164	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

Findings Include:

1) Observations on 09-04-13 at approximately 10:07 AM found the following foods designated for the 3-day supply of food: granola chewy bars (48 count), mandarin oranges (4 oz), three cans of apricot halves (15 oz), two cans of soup (2.5 oz), three cans of tuna, a jar of jelly, and tea packets. Observations found no other food items designated for the 3-day supply.

Observations on 09-04-13 at approximately 10:30 AM found the facility did not have a menu posted anywhere in the facility.

Observations on 09-05-13 at approximately 8:20 AM found resident #1 eating a piece of toast with jam. Observations on 09-05-13 at approximately 8:31 AM found staff #2 bring resident #2 four small muffins with a cup of coffee for breakfast. Observations found resident #2 was also served a cup of iced tea. Observations found resident #2 was also given a bowl of cut up watermelon. Observations found resident #1 requested muffins.

In an interview with resident #1 on 09-04-13 at approximately 10:40 AM, she stated she does not know what food she is going to be served. She stated she does not know of the facility having a menu. In an interview with resident #2 on 09-05-13 at approximately 10:59 AM, she stated she is not aware that the facility has a menu.

2) Record review of the facility menu revealed the following items were to be served on 09-05-13 for breakfast: orange juice, dry cereal or cooked cereal, scrambled eggs, bran muffin, 1 sl bacon {crossed out}, jelly, and milk.

2) Record review of the facility's menu revealed it was signed by a registered dietitian on 07-15-13. Record review of the facility menu revealed it was a menu designated for residents with a regular diet. Record review revealed the facility crossed out all pork items, including bacon and sausage, but did not make any substitutions. Record review revealed the facility did not have any previous menus kept on file.

Record review found a menu that the facility was following. Record review revealed the that menu was not completed or reviewed by a registered dietitian or a licensed dietitian/nutritionist.

Record review of resident #2's health assessment {AHCA Form 1823}, dated 05-24-13, revealed the physician indicated resident #2 needs a no added salt and a low fat/ low diet. Record review found no documentation of resident refusal of a therapeutic diet.

3) In an interview with the administrator on 09-04-13 at approximately 9:28 AM, he stated his current census was two residents.

In an interview with the administrator on 09-04-13 at approximately 10:07 AM, he identified the 3-day supply of non perishable foods. When asked if there was any other foods for the 3-day supply, he stated the food in the freezer could be used in case of an emergency. He stated that food is used on an every day basis. He stated he does not have a menu for an emergency. He stated he would serve sandwiches and things the residents ate daily and pull out of inventory.

In a interview with the administrator on 09-04-13 at approximately 10:10 AM, he stated that they do not post a

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menu. He stated he did not realize until recently that they needed one. He stated that they just got one. He stated that they have it but they have "not implemented as such". He stated if it were implemented it would not be used due to the residents have specific eating habits.

In an interview with the administrator on 09-04-13 at approximately 12:40 PM, he stated he was told recently that they had to have a menu and did not know before. He stated when he found out he got a menu signed by a dietitian.

In an interview with staff #1 on 09-04-13 at approximately 12:45 PM, she stated they only had menus for about a month because they did not realize the small facilities needed one. She stated there is a new one every week but does not have any from the past. She stated she made changes in the past but did not document it. She stated they do not do pork. She stated that there is no substitutions for sausage or bacon. She stated they just don't serve it.

In an interview with resident #2 on 09-04-13 at approximately 1:03 PM, she stated she will eat bacon and sausage but she prefers turkey bacon and sausage. She stated she will eat either or.

In an interview with staff #2 on 09-05-13 at approximately 8:38 AM, she stated she will ask the residents what they want for breakfast and will make it for them. She stated she has not been following a menu for it.

In an interview with resident #2 on 09-05-13 at approximately 9:05 AM, she stated she likes orange juice, cereal, scrambled eggs, and bacon. She stated she would eat all of them if they served it. She stated she does prefer turkey bacon though.

Class III

0160-Records - Facility 58A-5.024(1) FAC

Based on record review and interview, the assisted living facility failed to maintain an admission and discharge log.

Findings Include:

1) Record review revealed the facility did not complete an admission and discharge log. Record review revealed the facility had a document for admission and discharge but it was incomplete {blank} after request.

2) In an interview with staff #1 on 09-04-13 at approximately 3:22 PM, she stated she does not have an admission and discharge log . She stated they only have had four residents. She stated all that information is in their files. She stated the only log the facility has is the log for visitors.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated he did not know he needed an admission and discharge log. He stated he has a log near the front door that they use {visitor log}.

In an interview with the administrator on 09-05-13 at approximately 10:21 AM, he stated he filled out an

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admission and discharge log but he could not find it. He stated he thought it was to keep track of when the residents leave the facility.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they confirmed that they do not have a current and up to date admission and discharge log.

Class III

0162-Records - Resident 58A-5.024(3) FAC

Based on record review and interview, the assisted living facility failed to ensure that 2 out of 2 (resident #1, resident #2) current resident record reviews included documentation of the appointment of a health care surrogate, guardian, or the existence of a power of attorney.

Findings Include:

1) Record review of resident #1's file revealed her contract was dated 01-01-13. Record review revealed her contract and all documentation was signed by resident #1's daughter. Record review revealed their was not appointment paperwork found in resident #1's file.

Record review of resident #2's file revealed her contract was dated 08-25-13. Record review revealed her contract and all documentation was signed by her previous caregivers. Record review revealed their was not appointment paperwork found in resident #2's file.

2) In an interview with the administrator on 09-04-13 at approximately 12:15 PM, he stated the caregivers have resident #2's power of attorney. He stated the power of attorney for resident #1 is her daughter. He stated the facility probably does not have a copy of their power of attorneys. He stated resident #1 is not very competent but she has not been declared not in competent.

In an interview with the administrator on 09-05-13 at approximately 9:37 AM, he stated he did not know each resident needed to have the power of attorney appointments in their files.

In an interview with the administrator and staff #1 on 09-05-13 at approximately 10:42 AM, they confirmed that they do not have power of attorney paperwork for both resident #1 and resident #2.

Class III

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	AL11968150	**09/05/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Southern Breeze Living Llc	**18 Woodward Ln Palm Coast, FL 32164**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Southern Breeze Living LLC
Administrator
18 Woodward Lane
Palm Coast, Florida 32164

Dear Administrator,

This letter reports the findings of a standard biennial licensure inspection survey conducted on , 2013 and , 2013, by representatives of the Agency for Health Care Administration. Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's corrective action plan within **ten calendar days** of receipt of this report.

The inspection resulted in findings of non-compliance in the following areas:

1) A0051- Medication- Pill Organizers- Class II
The facility failed to ensure only residents who self-administer medications use a pill organizer. The facility did not ensure only licensed staff assist residents who use a pill organizer.

2) A0054- Medication- Records- Class II
The facility failed to ensure proper records were kept for residents using assistance with self-administration of medication for all residents currently residing at the facility. The facility failed to accurately maintain and complete resident medication observation records.

3) A0077- Staffing Standards- Administrator- Class II
The facility's administrator failed to be responsible for the running of an assisted living facility. The administrator failed to ensure compliancy with the rules and regulations which govern assisted living facilities in the state of Florida.

Directed Corrective Actions:

1) The facility shall immediately contract with an assisted living facility consultant for a minimum of two years.
2) The facility shall immediately consult a pharmacist to ensure all staff providing assistance with self-administration of medication are following the guidelines of 429.256, F.S.
3) The facility shall ensure all current staff is retrained and have all required trainings completed. Neither the administrator nor his wife shall act as the trainer on any of the trainings. All trainings shall be completed regardless if previously completed. Certificates should not be dated on or before , 2013.

4) The administrator shall register to complete a 12 hour CORE refresher class.

Please be advised that nothing in this DPOC limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call . Catherine Anne Avery, Survey and Certification Support Branch, at 850-412-4505.

Regards,

Robert E. Dickson
Field Office Manager
Division of Health Quality Assurance