STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910686	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Independence Hall	1639 NE 26th Street Fort Lauderdale, FL 33305

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

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0050 - 58a-5.0185(1) Fac - Medication - Self Administered Medications S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Assisted Living Facility standard biennial licensure survey was conducted on Independence Hall had licensure deficiencies found at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observations, interviews and record review, the facility failed to ensure AHCA Form 1823 (medical examinations) were updated or complete for 2 of 3 sampled residents (Resident #2 and Resident #12).

The findings include:

1. Resident #12 was admitted to the facility on . At his request and his family's request, he was admitted to hospice services on related to . Review of his record revealed a medical examination dated . The following sections were not filled out by the Health Care Provider: medical history and diagnoses, or behavioral status, special precautions, and current medications. Further review of his record revealed no updated medical examination as required when a resident experiences a significant change in condition such as determining the need for hospice services, required when an individual has a life expectancy of less than six months. In an interview conducted at 2:05 PM, the Administrator acknowledged the medical examination in the file was incomplete and should have been updated in 2013 when the resident started hospice services.

In addition, review of Resident #12's hospice Interdisciplinary Care Plan revealed no reference to assisted living facility staff. The Admission Open/Close Visit Checklist dated documented the plan of care was established with "Self/RN" and "[hospice] Physician"; with input requested from "Chaplain" and "Social Worker"; and, the following were involved in and verbalized understanding and agreement with plan of care were "Patient" and "Family". The boxes for "Facility Nurse", "Caregiver", "CC Staff", and "Other" were left blank. This was discussed with the Administrator on at 12:53 PM.

2. During record review of resident #2's record it was noted that the resident was admitted to the facility on The current Health Assessment dated was reviewed and there was no documentation of the type of medication assistance required by the resident. The health care provider did not check the box for either (1) needs assistance with medications or (2) needs medication administration. The medication LPN was interviewed on at 11:00 a.m. and confirmed the findings.

Class III

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0050-Medication - Self Administered Medications 58A-5.0185(1) FAC
Based on observations, interviews and record review, the facility failed to monitor and note deviations attributed to improper self-administration of medication for 1 of 2 sampled residents (Resident #12) whom demonstrated a need for assistance with self-administration of medications.

The findings include:

Resident #12 was interviewed and observed on at 1:20 PM. When asked if he ever runs out of medicine, he stated he does not take medicine, he thinks the pharmaceutical industry is a conspiracy to keep you sick so they can make money. After the interview, this writer requested and received permission to look in his The following medications were observed: prescribed ne/HCTZ 37.5 tablets, prescribed 40 milligrams (MG), over-the-counter (OTC) Bayer 325 MG, and OTC cream containing 8% and 1% Pramoxcine HCl. Also observed were 15 bottles of various OTC supplements. No drawers or cabinets were inspected. At that time, Resident #12 was asked and stated he did not remember having or taking the prescription or OTC medications; he did not know what they were for, and denied having any medical conditions that warranted him taking these or any medications.

Review of his records revealed Resident #12 is a male with and he has received hospice services since Review of his hospice records revealed the following medications, the location of which was not known by facility staff or the Resident's Hospice Nurse:

1. An Appropriateness Evaluation form dated documented "periods of and forgetfulness".

2. A Nursing Initial Comprehensive Assessment form dated documented "disorientation" and the comment "Hate pain pills, I despise taking any medications " and " Has private caregiver that visits daily to give him his meds ... " .

3. His most recent Nursing Updated Comprehensive Assessments dated and documented " disorientation " .

4. His most recent Active Medication Profile dated revealed sections titled "Medications administered by" and "Patient denies use of over-the-counter medications" with nothing checked off. The medication profile listed the following medications:
a. solution 10 grams (G)/15 milliliters (ML) daily
b. tablets 8.6 MG daily
c. tablets 40 MG daily
d. tablets 37.5 MG daily
e. tablets 325 MG, 2 tablets every 4 hours as needed for pain or
f. cream 1%, apply to affected area daily as needed for itching
g. ointment 20%, apply to affected area twice daily as needed for or itching

5. The medication profile also including a hospice "comfort pack" containing the following medications which was stored in the Resident's refrigerator:
a. 650 MG applied every 6 hours as needed for mild pain or

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b. 1% drops, 2 drops under tongue every 4 hours as needed for excess secretions
c. Bisac-Eval daily as needed for
d. 2 MG/ML, 0.5 ML by mouth or under tongue every 6 hours as needed for agitation
e. 1 MG by mouth every 6 hours as needed for
f. 100 MG/5 ML, 0.25 ML by mouth or under tongue every 4 hours as needed for g. moderate to severe pain or
h. 10 MG 1 tablet by mouth every 6 hours as needed for and

During an observation and interview conducted at 9:10 AM with the Administrator present, Resident #12 was queried again and stated he thinks medicine is not good for you and are a political ploy to get your money. Two bottles of OTC supplements, one for memory and one for good health were observed on the dining table; he confirmed he took these supplements. Then he gave us permission to look in his With the Administrator present, observations were made of the same medications from the previous day, plus the following OTC medications: drops containing 7.5 MG and HBR 5 MB, and cream containing USP 1%. Another count of bottles of supplements totaled 21 bottles. Again no drawers or cabinets were inspected at this time.

Further review of the two prescribed medications present revealed the following:
1. Both were ordered for one tablet daily and were filled at a quantity of 90 tablets each.
2. The ne/HCTZ was filled on and 5 tablets remained in the bottle. If they were taken as ordered, the pills would have run out on
3. The was filled on and 15 tablets remained in the bottle. If they were taken as ordered, the pills would have run out on

Resident #12's Hospice Nurse was interviewed on at 12:53 PM and provided the following information. She documented his "disorientation" on multiple nursing assessment forms, and did not check off who was administering the medications on his medication profile, but she would have checked off "caregiver" and written in the resident's private duty aide's name. Resident #12 made multiple statements regarding "hates to take medicine", she thinks he does not take the OTC supplements, and thinks he does not always take his prescription medications either. She believed his private duty aide was storing and giving him his medications.

In an interview conducted in Resident #12's at 9:10 AM, the Administrator stated she agreed Resident #12 demonstrated he was not able to safely self-administer his medications. She acknowledged hospice and facility staff should have monitored and reported the medications and supplements identified herein. She stated Resident #12 has a private duty aide hired by the family and did not know what her qualifications were. She also acknowledged facility staff were responsible for ensuring medications were stored and taken in a safe manner.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observations and interviews, the facility failed to provide a safe living environment, free from hazards, for the residents on the first and second floors.

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The findings include:

1. On . at 10:30 a.m. during a tour of the second floor with the facility nurse, the door to . . . was observed to be open. The surveyor went inside, and the . . . observed to be under renovation. In the living area of the . . . were several nails, screws, and other types of hardware laying loose on top of a rusted container. In the back of the . . . were paint cans observed on the floor, and in the kitchen area a large refrigerator had been pulled away from the wall. There was no one in the . . . The nurse stated that the . . . was . . . being renovated. The door to the . . . observed to be warped and unable to close all the way. In addition, there were residents observed in the vicinity. On . . . at 11:35 a.m. the Administrator was interviewed. She observed the open door to . . . and stated the door should be kept locked during renovation. On 11. at 12:00 p.m. the door to . . . was observed to again be open with the nails, screws and other construction debris still in plain view.

2) The men's resident . . . on the first floor noted to have offensive . odor. Further observation noted that laminate floor was stained yellow around the toilet. Floor drain also noted to be a potential trip hazard as it was observed to be recessed into the floor over 1 inch.

3) One of the ceiling mounted air-conditioning vents was noted to be not properly secured and falling away from the ceiling. Further observation noted that 1 of the screws holding up the vent to the ceiling was missing.

4) Resident . . . noted that the . tiles (X 4) around the toilet had come loose from the floor and were protruding up- ward. It was also noted that the floor tiles(X 3) in the kitchen area in front of the refrigerator had come loose and were protruding upward. Both issues were a potential trip hazard to the residents. Interview with Resident # 3 (residing in . at the time of the observation confirmed the damaged floor and possible trip hazard.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Independence Hall
1639 NE 26th Street
Fort Lauderdale, FL 33305

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative of this office.

Attached is the provider's copy of the State (5000-3547) 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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