RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016
Amended

Administrator
Am Grand Court Lakes, Llc
280 Sierra Drive
North Miami Beach, FL 33179

Dear Administrator:

This letter reports the findings of a revisit inspection survey conducted on by representatives of the Agency for Health Care Administration (Agency). 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 Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:
St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 429.26(7) Fs; 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28(1-2) Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0050 - 429.256(2) Fs;58a-5.0185(1) Fac - Medication - Self Administered Medications S-S= G
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Directed Corrective Actions: The Assisted Living Facility is required to

1. Conduct assessments immediately on all current residents, and on all future residents upon admission. These assessments must address the level of assistance with activities of daily living and level of supervision needed to meet the residents' needs and must identity whether the residents are appropriate for residency in the facility. **This task must be implemented by**

2. conduct daily observation of the general health and emotional well-being of the resident. Residents under risk of or who have special needs will be evaluated in order to have them appropriately supervised. A new assessment must be conducted on all residents within 24 hours of any change of behavior where a resident demonstrates repeated or other behaviors which might result in injury. The assessments must be completed by staffs who are fully trained in the facility's assessment and care procedures and who are qualified to make an accurate evaluation of whether the resident's conditions may be managed by on the premises

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and within the scope of the facility's license. When it is necessary to make alternative placement arrangements for a resident who cannot safely live in the facility, these arrangements must take place in a way that does not violate resident rights and/or dignity. **This task must be implemented by**

3. The written assessment, and documentation of follow up actions taken to ensure the residents' safety, signed by the person conducting it, must be kept on file at the facility, and be available for review by the Agency. If any resident demonstrates repeated or other potentially injurious behaviors, the facility must contact the resident's health care providers and family members, and must collaborate regarding the course of care. These contacts and the course of care must be documented in the resident's file. **This task must be implemented by**

4. The facility must periodically review and assess all residents who self-administer medications without staff support. The assessment must determine the resident's physical and mental capacity to take medications without assistance remains intact and should also develop policies and procedures for dealing with it. **This task must be implemented by**

5. The facility must complete in-service training for all staff, including owners and others involved in operating the facility, regarding resident supervision as it pertains to Florida Administrative Code 58A-5.0182(1). The training must include elements which instruct staff on how to recognize when a resident's needs for supervision by and assistance from staff has changed; how to provide the needed supervision in order to ensure resident safety; how to provide effective and competent communication with medical providers and family members; and how to ensure that residents who have a significant change of condition obtain medical and/or care immediately. The training must have an agenda and sign-in sheet. The training documentation must be kept on file at the facility and available for review by the Agency. **This task must be completed by**

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

Should you have any questions, please contact Sonia Bailey, Health Facility Evaluator Supervisor, Miami Field Office, (305) 593-3100

Sincerely,

Arlene Mayo Davis, RN
Field Office Manager

AMD/sb

D7JR

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, 2016

Administrator
Am Grand Court Lakes, Llc
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Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on 29, 2016 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2017.**

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 Sonia Bailey, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

YOSF

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953671	R 11/29/2016
NAME OF PROVIDER OR SUPPLIER **AM GRAND COURT LAKES, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **280 SIERRA DRIVE** **NORTH MIAMI BEACH, FL 33179**	

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

0000 - Initial Comments

A Revisit Survey was conducted on 28, 2016 and concluded on . 29, 2016. AM Grand court Lakes, LLC (License #8390) had the following deficiencies identified at the time of the survey:

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review an interview, the facility failed to provide documentation of an updated face-to-face medical examination by a health care provider (AHCA form 1823) after a significant change for 3 out of 50 sampled residents (#4, #43 and #44).
Findings included:
On at 1:20 p.m. Observed Resident # 44, sitting in a wheelchair, in resident ' s . His bed had full bed rails on both sides.
Record review revealed that Resident #43 ' s health assessment dated listed diagnoses of , chronic A-fib. The resident had physical or sensor limitation that ambulated with a walker. Further record review revealed that Resident #43 ' s activities of daily living (ADL) stated he was independent with transferring and needed supervision with bathing and dressing. On / Resident # 43 went to the hospital emergency was diagnosed with a head injury. On progress note by a physician dated showed that resident was wheelchair bound.
A review of Resident #44 ' s health assessment dated showed medical diagnoses: Hx: right femur , prostatic hyperplasia ( ), , history of , abnormality of gait, ( ), ( ).His physical or sensor limitations revealed that Resident required with all ADL and transfer. Nursing/ treatment/ services revealed " medication administration and management by resident " .
Resident #44 activities of daily living (ADL ' s) showed that he needed supervision with eating and self-care; assistance's with bathing and dressing and " Total care with ambulation, toileting and transferring.
A review of Resident #4 ' s record revealed that the resident was admitted on , AHCA 1823 dated , showed diagnoses of II, Chronic Kidney , obese, dependent. The Resident needs assistance with ambulation, was independent with bathing, dressing, eating, self-care, toileting, transferring. Special diet no added salt, low fat/low . The resident needed assistance with self-administration of medications.
A review of Resident #4 ' s progress notes revealed, on , resident ' s primary care physician placed called to facility with order that resident was able to self-administer all medications.
On at 5:18 PM Resident #4 stated " I am able to manage my own medication, and I inject

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my daily and I have my in my room. The staff will usually check up on me 3 to 4 times a day. If I need something I can call the front desk and they will take 15 minutes to get here. I can bathe and dress on my own. On I was sitting on my wheelchair and I got up to go to the when I stood up I felt , and I put my hand over my forehead because I tried to protect my head and I my right pinky ring. I didn ' t call anybody because I was able to get up on my own. I did tell them at the nurse ' s station, because I didn ' t want them to think I twice that same day, I was by the pool by the elevator, I got my leg caught and it took a chunk of my skin. I do not recall what happened first. I told the nurse and they called the emergency department. In the hospital, I was tested positive for .. When I came back from the hospital I was supposed to receive care, but they never came and my injury got , so I went to the hospital again.
UNCORRECTED
Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review and interview, the facility failed to provide care and services appropriate to meet the needs of five out 50 (Resident #37, 43, 44, 46, 50) sampled residents. Bedbound resident #43 and acquired a head injury. Resident #44 and broke his hip.

Findings included:

On at 6:11 AM, Staff V24 stated, he does not know how many residents are in the facility. He showed a census form dated which identified the census on that day as 126.

On at 6:12 a.m., staff V25, a Home Health Aide (HHA) stated, she had been working at the facility for about four months, and she did not know the census. Staff V25 opened the memory care unit and, stated that there were residents living on floors 2 & 3.

On at 6:19 a.m., Staff H was in , she said staff V23 was on duty with her. She stated, they only had 6 residents on the unit/floor, and that only floors 2 and 5 were in use. She states, there were about 17 people on the 5th floor and she was providing care to 7 of them.

On / at 7:45 A.M., during the facility tour of building C with Staff L-12 (the kitchen manager), it was observed none of the staff was in the hallway. Facility Staff L-12 stated, "we have one staff in this building but at this time she is assisting residents in their .. We have one elevator that is out of order. "I don't know where she is. She has a phone that she can be called on."

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On 10/28/2016 at 7:02 AM, Staff R stated, the front desk guard should have known the census, and he had a sheet from the night before.

On at 7:10 AM, observed 2 staff signing off the hourly rounds sheets from 3:00 am to 7:00 am. Staff C stated, staff does not have time to initial the round/observation/care logs because they are bathing residents during those hours, so they sign the sheet before they leave their shift. She further stated, it can take around 30 minutes to shower the residents who are . When asked how staff can sign off that they have seen all of the other residents during the time that they were showering someone, since they are not making the rounds at those times. Staff C stated, they just do the best they can, trying to recall that residents were okay the last time they saw them.

Reviewed the internal incident log for and of 2016, and monthly care logs for 2016 and identified several residents with hospitalizations or . Forty-six (46) residents who had monthly care logs indicating that they needed or received assistance with adult incontinence briefs.

Review of Resident #46's file showed that the resident was on Hospice, had an order for a hospital bed with rails. Further review showed that the hospice Plan of care (POC) was updated on .

On at 8:55 am, Staff V22 confirmed, Resident #46 is bedbound. The health assessment (Agency for Health Care Administration, AHCA form 1823) showed that he needed assistance with ambulation. Further review revealed Resident # 46 can not bathe, dress, eat, toilet, or transfer independently. Form 1823 documented assistance for all activities of daily living (ADL's). The resident received hospice services three times per week. The resident needed administration of medications, Meds are administered two times per day according to the 1823 (8 a.m. & 5 p.m.). Resident #46 has a puree diet ordered and crushed meds ordered. The resident had lost 12 lbs. since admission on /

Record review on revealed that Resident #43's health assessment (AHCA form 1023) dated showed diagnoses of , ( ), , ( ), ( ), , chronic A-fib. The Resident had physical or sensor limitations and ambulated with a walker. Further record review revealed that Resident #43's activities of daily living (ADL's) showed he is independent with transferring and needed supervision with bathing and dressing. On /, Resident # 43 went to the hospital emergency had a diagnosis of a head injury. On /, a progress note by a physician dated showed the resident was wheelchair bound.

On at 11:40 AM Resident #37 stated, "I do not remember how long I have been here. I can

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stand up, but I can only walk little steps because I am not strong enough. Yes, I wear adult briefs, if I need to have my brief changed I will call them and I will let them know. I have my own phone. At night they will come to change me maybe once, occasionally once in a while they will leave me with my diaper unchange until the point that it becomes uncomfortable. "

On at 12:25 PM Resident #44 stated, "Yes, I take my own medication, I keep it in a cabinet in the . I have had about 6 in the past six months. I had a on , 2016, I squashed my , I was being stubborn and I tried to get from the bed to the nightstand. I didn't use my walker and I . I had a placed; my doctor said that will help me because I had a low rate. " At 1:20 P.M. -201 was observed, Resident #44 was sitting in a wheelchair. The resident's bed had an attached full bed rail on both sides. The Resident stated, "I can not remove the full bed rail by myself. I called staff to help me to get out of the bed. They take 15 minutes or 20 minutes to get in here. I have to wait because sometimes they are helping another resident." He stated this is understandable. He stated, I'm calling them and they do not answer me.

On at 2:43 P.M., observed Resident #50 in a wheelchair in front of the table. Record review showed that the resident was and was on a list of residents who needed staff assistance for toileting and .He stated, "usually we have two staff, but today we have only one staff. They change my briefs two times a day only. "

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview, the facility failed to prevent the use of physical with a full bed rail, for one out of 50 (#44) sampled residents that is not receiving hospices care. The facility failed to treat with consideration and respect due to recognition of personal dignity and to have staff that are able to communicate with Resident #42 with a hearing . The facility failed to respect Resident #47 ' s private area by storing other residents and staff belongings.

Findings included:

Observation on at 1:20 p.m. during facility tour building C, # -201 Resident #44 bed did have attached full bed rail at both sides of his bed.

Record review on showed Resident #44 ' needed supervision with toileting and . Resident #44 lost 12 lbs. since / . The med sheet revealed that Resident #44 self for

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administration for hctz and other meds for 2016 and 2016. Health assessment (AHCA form 1823) showed that Resident #44 did needs assistance with self-administration of medication in 2 places. The facility did not have documentation on record that reviled that resident received hospices care for the use of full bed rail or resident consent to the use of bed rails.

During an interview on at 1:20 P.M. Resident #44 ' stated "I cannot remove the full bed rail by myself. " I called facility staff to help me to get out of the bed. He stated they took 15 minutes or 20 minutes to get here. I have to wait because sometimes they are helping another resident. This is understandable. "

On during facility tour at 6:06 AM, Observed in Resident #47' s , adult briefs, women ' s deodorant, and some bags on the counter in the common area of the unit.

On during facility tour at 6:06 AM, Staff V23 stated that "This is "staff stuff " ; these items are used by the other staff person; she stores them there to change and bathe residents on the floor. "

On at 2:34 PM- asked Staff R18, how they communicate with the Resident #42, especially if there is an emergency. Observed Staff L12 trying to communicate with the resident by yelling. Resident #42 did not respond. She touched the resident on the shoulder and he opened his eyes, waving & smiling, motioning that he was . Staff R18 was then observed trying to communicate with resident. Resident #42 observed guessing at what Staff R18 is saying. (Staff R18 appeared to be gesturing to ask if the resident wanted a snack; Resident #42 responded saying that he had already taken a shower. Staff R18 claims to know a small bit of sign language. Asked Staff R18 if he could then interpret while Resident #42 was interviewed, but staff R18 stated that he does not speak sign language officially and could not interpret.

On at 3:24 PM interview, with Staff V22 when asked how staff communicates with Resident #42- stated that staff makes gestures and speaks loudly to him and he seems to understand. Staff stated that there is no one on staff who speaks sign language that she is aware of.

On 3:25 PM Interview, with Staff V22 and Staff R stated that there is no policy/procedure that they know of about how controlled meds are handled. The pharmacy told, the DON that ALFs do not need one. When the pharmacy delivers meds, the med techs receive them. For independent residents, they give the meds directly to the residents. Asked how they track meds to ensure that residents receive them from staff, Staff V22 stated that residents tell her if they need anything, or if their meds are missing. Stated Resident #44 never told her any meds were missing.

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On 10/28/2016 during facility tour at 6:06 AM, Observed in Resident #47 ' s room, adult briefs, women ' s deodorant, and some bags on the counter in the common area of the unit.

On during facility tour at 6:06 AM, Staff V23 stated that this is " staff stuff " ; these items are used by the other staff person; she stores them there to change and bathe residents on the floor.

On at 2:34 PM- asked Staff R18, how they communicate with the Resident #42, especially if there is an emergency. Observed Staff L12 trying to communicate with the resident by yelling. Resident #42 did not respond. She touched the resident on the shoulder and he opened his eyes, waving & smiling, motioning that he was . Staff R18 was then observed trying to communicate with resident. Resident #42 observed guessing at what Staff R18 is saying. (Staff R18 appeared to be gesturing to ask if the resident wanted a snack; Resident #42 responded saying that he had already taken a shower. Staff R18 claims to know a small bit of sign language. Asked Staff R18 if he could then interpret while Resident #42 was interviewed, but staff R18 stated that he does not speak sign language officially and could not interpret.

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Class III

0050 - Medication - Self Administered Medications - 429.256(2) FS;58A-5.0185(1) FAC

Based on observation, interviews and record review, the facility failed to recognize health changes that could be reasonably attributed to the improper self-administration of medication, and failed to consult with one of 50 sampled residents (Resident #44) about problems in self-administering medications. Resident #44 was found with over twenty bottles of unconsumed medication, and experienced three with injury, one resulting in a broken hip. After a , the resident was diagnosed with low and

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Findings:

On 10/28/2016 at 12:25 PM Resident #44 stated, " I take my own medication, I keep it in a cabinet in the bathroom. I have had about 6 in the past six months. I had a on 26, 2016, I squashed my , I was being stubborn and I tried to get from the bed to the nightstand. I didn't use my walker and I . I had a placed; my doctor said that will help me because I had a low rate. " At 1:20 P.M. -201, observed, Resident #44 was sitting in a wheelchair. The resident's bed had an attached full bed rail on both sides. The Resident stated, "I can not remove the full bed rail by myself. I called staff to help me to get out of the bed. They take 15 minutes or 20 minutes to get in here. I have to wait because sometimes they are helping another resident. I'm calling them and they do not answer me. "

On at 2:30 PM, during a tour of Resident #44's , observed that there was a bottle of on the dresser.

On at 5:20 PM, observed in Resident #44's , several of the medications in the , several tanks, and injections on top of the dresser.

On at 5:35 PM, arrived to Resident #44's Staff V22, and observed several medication bags from a pharmacy with medication inside the bags. Several of the medications were observed to have different dates.

On at 5:51 PM, during a tour with staff V22 observed, Resident #44's was unlocked. Observed over 20 medication bottles were scattered widely around the , some still in bags from the pharmacy. The resident stated that once, his was not received. He contacted the pharmacy and was told that the medications were delivered to the facility and signed for by staff. The next time (a week or so later), he went himself, in person, to pick the medications up. Medications observed in the residents : Pradaxa 150 MG 1 cap 2 x a day , Spray 1 spray daily one box. , Ocuvite 1 tab daily bottle , 10 GM 15 ML one bottle of liquid. 325 MG 1 tab daily one bottle , Olapatadine 665 MCG nasal spray spray daily , Oxybutinin 10 mg 1 tab daily one bottle , 4 mg 1 tab by night time one bottle , 25 mg 1 cap by night one bottle , 40 mg 1 tab daily one bottle , 20 mg 1 tab by night , 40 mg 1 tab daily one bottle , 4 mg 1 tab daily one bottle. , 20 mg 1 tab daily one bottle. , 10 mg 1 daily one bottle , 4 mg 1 daily one bottle , 20 mg 1 daily one bottle , 160-12.5 mg 1 daily one bottle , Nasal spray, one

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bottle, 0-328 MG every 4 hours 10/26/2016, 1 mg daily one bottle 09/06/2016, 10 mg daily 10/24/2016, 12% daily , 10 g/mg daily . In medicine cabinet 160-12.5 MG 1 daily one bottle , 10 mg 1 daily one bottle , 40 mg daily one bottle , Pradaxa 150 mg daily one bottle , 20 mg daily one bottle , 1 mg daily one bottle , 5 MG 1 daily one bottle , 25 mg 1 daily one bottle , 20 mg 1 daily one bottle , 4 mg 1 daily one bottle , 10 mg daily one bottle .

A review of facility records showed that Resident # 44 in the facility dining ambulating with a walker on , 2016, and broke his hip. The resident had surgery went to a rehabilitation facility for six weeks before returning to the facility. The resident was recommended to have precautions.

A review of the hospital records for Resident #44 revealed, on at 12:29 P.M. he was transferred to the Emergency a , comments: The record stated, " while trying to get in to bed at 4 a.m. Complaint of pain to right hip/ since the . He is concerned about prior right hip surgery that he had in . "On at 3:32 P.M. Patient discharged home to the assisted living facility with instructions given, verbalized understanding, left message with facility nurse director and front desk of facility in regards to updating on patients status."

A review of resident #44's progress notes showed the resident was admitted to the hospital on / and discharged on ; on at 5:45 A.M. The physician charted that Resident #44 complained of a low , (LBP), stemming from a 6 days earlier. Patient history of present illness stated: The patient presents complaining of lower back pain. He stated that he several days ago but did not seek medical care at the time. Hospital Course: patient was admitted for observations. He was placed on pain control. He was continued on his usual medications. During the hospitalization patient was noted to be bradycardic and to have pauses. He was seen by EP and underwent a , placement.

A review of resident #44's progress notes showed the resident was returned to the facility from a hospitalization on / for an unknown reasons. The resident kept medications prescribed at discharge. There was no documentation that staff observed the resident or his ability to self-administer the medication.

A review of Resident #44's record showed that there was no documentation of staff observing the surplus of medication in the resident's . Further review showed that there was no documentation of staff speaking with the resident about having his ability to self-administer his medications reevaluated.

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A review of Resident #44's health assessment dated 10/26/16 (AHCA form 1823) showed "Medication administration by resident." There was no documentation in the resident's file showing that staff contacted the resident's health care provider to report or coordinate care regarding the excessive unconsumed medication in the resident's the numerous with injury.

Class II

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

Based on observation and interview, the facility failed to ensure medications were kept secured in a locked container at all the times.
Findings:
On at 2:30 PM observed in - Resident #44 ' s medications observed in various places around the , however medication bottles were scattered widely, some still in bags from the pharmacy. Resident stated that once, his was not received. He contacted Walgreens and was told that the meds were delivered to the facility and signed for by staff. The next time (a week or so earlier), he went himself, in person, to pick the meds up and did get them that way. "
On at 3:05 PM spoke with pharmacist at Walgreens regarding Resident 44 ' s
She stated that the previous prescription was filled on 5 and was delivered to the facility on 7 and was signed for by a staff person (first name could not be read), along with a prescription . She Stated that the next prescription, 18 or 19, was hand- carried in by the resident, who received the medication himself.
On at 3:25 PM Interview with Staff V22 and Staff R stated that there is no policy/procedure that they know of about how controlled meds are handled. The pharmacy told Staff V22 ' s that ALFs does not need one. When the pharmacy delivers meds, the med techs receive them. For independent residents, they give the meds directly to the residents. Asked how they track meds to ensure that residents receive them from staff, Staff V22 stated that residents tell her if they need anything, or if their meds are missing. Stated Resident #44 never told her any meds were missing. "
On at 5:51 PM Observed, Resident #44 ' s was unlocked, medications observed in residents : Pradaxa 150 MG 1 cap 2 x a day , Spray 1 spray daily one box. , Ocuvite 1 tab daily bottle , 10 GM 15 ML on bottle liquid. 325 MG 1 tab daily one bottle , Olapatadine 665 MCG nasal spray spray daily , Oxybutinin 10 mg 1 tab daily one bottle , 4 mg 1 tab by night time one bottle , 25 mg 1 cap by night one bottle , 40 mg 1 tab daily one bottle , 20 mg 1 tab by night , 40 mg 1 tab daily one bottle , 4 mg 1 tab daily one bottle. , 20 mg 1 tab daily one bottle. , 10 mg 1 daily one bottle , 4 mg 1 daily

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953671	R 11/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AM GRAND COURT LAKES, LLC	**280 SIERRA DRIVE NORTH MIAMI BEACH, FL 33179**

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

one bottle 10/24/16, 20 mg 1 daily one bottle 10/24/2016, 160-12.5 mg 1 daily one bottle 10/24/206, Nasal spray, on bottle, 0-328 MG every 4 hours , 1 mg daily one bottle , 10 mg daily , 12% daily , 10 g/mg daily . In medicine cabinet 160-12.5 MG 1 daily one bottle , 10 mg 1 daily one bottle 40 mg daily one bottle , Pradaxa 150 mg daily one bottle 20 mg daily one bottle , 1 mg daily one bottle 5 MG 1 daily one bottle , 25 mg 1 daily one bottle 20 mg 1 daily one bottle , 4 mg 1 daily one bottle 10 mg daily one bottle .

On at 2:30 PM observed, in Resident #44 ' s , there was a bottle of on the dresser.
On at 2:25 PM observed unlocked suppositories for Resident #48 in the refrigerator in the 2nd floor dining .
On at 5:35 PM Arrived to Resident ' s #44 ' s Staff V22, and observed several medications bags from Walgreens with medication inside the bags. Several medications were observed to have different dates around resident ' s .
On at 2:25 PM interview with Staff R18 stated that hospice staff had left it there because they had no other refrigerator to use.
Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on record review and interview the facility failed to provide a therapeutic diet for one out of 50 sampled residents (Resident and #51).

Resident record review conducted on showed the following:

Resident # 51's health assessment AHCA form 1823 dated / had diagnoses of , , small bowel obstruction (with ostomy); chronic kidney state , , , hyperkalemia. He did not have physical limitation; X3; required . Services provided through Home Health. Resident is independent with all ADLs. Resident has special diet (Diet). The resident needed assistance with self-administration of medications. The record showed that the resident did not have a refusal of therapeutic diet signed by the resident or responsible person.

On at 5:00 P.M., the facility did not have a diet posted on the wall and Resident #51's

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SUMMARY STATEMENT OF DEFICIENCIES
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name was not listed on the special diet list.

On 10/29/16 at 6:44 p.m., resident # 51 stated, "I do not receive my diet properly. I avoided things that I know that I cannot eat but I like to cheat a little bit."

At 7:02 P.M. Staff V22 (an RN) stated, "I received a diet yesterday from a center, I made a copy for the kitchen but it was not posted because Staff L-12 was gone for the day." It was stated the resident do not want to follow the diet.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the facility failed to file an Adverse Incident Report regarding resident ' s that resulted in an injury, for one out of 50 sampled residents (Resident #44).
Findings included:
Reviewed of the incident report database revealed there were no adverse incident reports completed for Resident #44 that had a which resulted in a hospitalization on .
A review of Hospital records for Resident #44 that revealed that on at 12:29 P.M. he was transferred to Emergency a , comments: " while trying to get in to bed at 4 a.m. complaint of pain to right hip/ since the . He is concerned about prior right hip surgery that he had in . "
Interviewed with Administrator on / at 8:20 AM, stated she was not sure if the previous Administrator had file an adverse incident report regarding the incident on this date.

Uncorrected Class III