

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

PRINTED: 04/26/2017  
FORM APPROVED

|                                                                             |                                                                                          |                                                     |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                                   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11968530</b>              | (X3) DATE SURVEY COMPLETED<br><br><b>04/12/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>A &amp; J ALF OF FLORIDA INC, II</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>808 GILLEN AVE NW<br/>PALM BAY, FL 32907</b> |                                                     |

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

**0000 - Initial Comments**

A Change in Ownership (CHOW) survey was conducted on \_\_\_\_\_ and \_\_\_\_\_ A & J ALF of Florida Inc. II, license #12391 had deficiencies at the time of the visit.

**0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC**

Based on observation of medication prescription labels, record reviews, and interviews, the facility (#3).

Findings:

Review of a health assessment form 1823 dated \_\_\_\_\_ for resident #3 revealed he required assistance with his medications.

Observation of his medication containers revealed a prescription label dated \_\_\_\_\_ that indicated \_\_\_\_\_ 50 milligrams (mg) give 1 tablet by mouth twice a day. "Twice a day" was crossed out and hand written instructions reflected that the medication should be given one time per day.

During an interview with the administrator on \_\_\_\_\_ at 11:52 AM, she said a hospice nurse changed the directions on the label because a new order was received from a health care provider.

The facility did not place an alert label on the medication container or obtain a revised label from the pharmacist when the directions for the medication changed, as required.

Class III

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

Based on record reviews and interviews the facility failed to ensure all required documents were maintained in the resident record for 1 of 2 sampled residents (#2).

Findings:

Record review for resident #2 revealed a health assessment form 1823 dated \_\_\_\_\_ that indicated she required assistance with her medications.

Review of her informed consent regarding assistance with self-administration of medications revealed the section that indicated whether the unlicensed staff who assisted with self-administration of medications would or would not be overseen by a licensed nurse was not answered.

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

PRINTED: 04/26/2017  
FORM APPROVED

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                          |                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11968530</b>              | (X3) DATE SURVEY COMPLETED<br><br><b>04/12/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>A &amp; J ALF OF FLORIDA INC, II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>808 GILLEN AVE NW<br/>PALM BAY, FL 32907</b> |                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          |                                                     |
| <p>On ..... at 4:00 PM, the administrator confirmed the finding.</p> <p>Class III</p> <p><b>0163 - Records - Resident, Penalties for Alteration - 429.49 FS</b></p> <p>Based on record reviews and interviews the facility failed to ensure resident records were not altered or falsified for 2 of 2 sampled residents (#2 &amp; #3).</p> <p>Findings:</p> <p>Review of the ..... 2017 Medication Observation Record (MOR) for resident #2 revealed entries for ..... 10 milliequivalents (meq,) 1 tablet by mouth two times a day at 8 am and 8 pm, ..... 0.125 milligrams (mg,) 1 tablet by mouth daily at 8 am, ..... 500 mg, 1 tablet by mouth two times a day at 8 am and 8 pm, ..... 1 mg, 1 tablet by mouth once a day at 8 am, ..... 325 mg, 1 tablet by mouth two times a day at 8 am and 8 pm.</p> <p>Review of the ..... 2017 MOR for resident #3 revealed an entry for ..... 50 mg, 1 tablet daily at 8 am.</p> <p>Continued review revealed the staff initials for the 8 am doses on ..... for residents #2 and #3 were altered.</p> <p>During an interview with staff A on ..... at 11:00 AM, she said she gave residents #2 and #3 their medications that morning. She said staff D told her she was not supposed to sign the MOR and staff D signed her own initials over the initials of staff A.</p> <p>On ..... at 11:00 am, the administrator confirmed the MORs were altered and confirmed the initials were those of staff A and staff D.</p> <p>Class III</p> <p><b>Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS</b></p> <p>Based on observations and interviews, the facility failed to ensure 1 of 5 staff (E) who required a background screening, did not have any disqualifying offenses and allowed staff E to work without an eligible background screening.</p> |                                                                                          |                                                     |

**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

PRINTED: 04/26/2017  
FORM APPROVED

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                          |                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11968530</b>              | (X3) DATE SURVEY COMPLETED<br><br><b>04/12/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>A &amp; J ALF OF FLORIDA INC, II</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>808 GILLEN AVE NW<br/>PALM BAY, FL 32907</b> |                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                                     |
| <p>Findings:</p> <p>Observations made during the entrance to the facility on . . . . . at 9:30 AM revealed the presence of staff E who identified herself as a facility employee who did the laundry and who assisted with resident care when her help was needed.</p> <p>During an interview with staff A, a caregiver, on . . . . . at 10:56 am, she said staff E assisted her that morning with getting a resident out of bed.</p> <p>Review of the facility staffing schedule revealed staff E was not listed.</p> <p>On . . . . . at 4:00 PM, a request was made to review the background screening results for staff E. The administrator said a background screening was not conducted on staff E, because she was not a resident caregiver, she only did the laundry.</p> <p>Unclassified</p> |                                                                                          |                                                     |