STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11969011	**08/10/2017**
NAME OF PROVIDER OR SUPPLIER **ASSISTED LOVELY LIVING FACILITY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1702 TRIMBLE RD** **MELBOURNE, FL 32934**	

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

0000 - Initial Comments

A complaint investigation #2017006439 was conducted on . Assisted Lovely Living Facility license #12837 had deficiencies at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview the facility did not ensure a resident admitted to the facility met the minimum criteria in order to be admitted for 1 of 4 sampled residents (#2).

Findings:

Resident record review for resident #2 revealed a health assessment report 1823 dated that listed diagnoses of major , , , , and severe memory loss. She needed administration of her medications; 24-hour nursing supervision and her needs could not be met in an assisted living facility and was an elopement risk

In an interview on at 3:30 PM with the administrator, who stated she did not realize that the information was incorrected. The resident never attempted to leave or go near the exits.

Class III

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

Based on record review and interview the facility failed to maintain a written record, updated as needed, of any significant changes, contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change (weight loss) for 2 of 4 sampled residents (#2 and #3).

Findings:

1. Resident record review for resident #2 revealed a health assessment report 1823 dated that listed diagnoses of major , , , , and severe memory loss. She needed administration of her medications. She needed assistance with bathing, dressing, , , and toileting. The health assessment report indicated a weight of 233 pounds.

The facility weight log indicated the following:

- 225 lbs.

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- 185 lbs.
- 170 lbs.

2. Resident record review for resident #3 revealed a health assessment report dated that listed , left , , , abnormal gait and memory loss. The health assessment did not list a weight.

The continued review revealed the following weights:

- 115 lbs.
- 105 lbs.
-115 lbs.
-105 lbs.

The review revealed there were no written notes to confirm the residents' healthcare providers were notified of the residents' fluctuations in weight.

In an interview with the administrator on at 3:30 PM who said the Advanced Registered Nurse Practitioner (ARNP) came to the facility monthly to see the residents. The residents' weights were taken at the time of her visit, so the facility did not keep notes because the ARNP was aware.

Class III

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

Based on observations and interview the facility failed to ensure the unlicensed staff (A) who assisted 1 of 4 sampled residents (#1) with self-administration of medications followed the correct procedure.

Findings:

Observations on at 12:30 PM noted staff A, caregiver, assisted resident #1 with assistance self-administration of medication in the following manner: reviewed Medication Observation Record (MOR), took three medication packages (bubble packs) from locked cabinet, put the pills one at a time in a cup, put the bubble pack in cabinet, closed the cabinet and signed the MOR. Then she took the medications to resident, told her what the pills were and observed the resident take the medications.

In an interview with the administrator on at 3:30 PM who said that the staff followed the process

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she was taught in a class.

Class III

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

Based on observations, record reviews, and interviews the facility failed to ensure a licensed nurse was available to administer medications for 1 of 4 sampled residents (#2).

Findings:

Observations on the medication cabinet noted resident #2 had six pill organizers. Each compartment was dated from 1 to 31 and Sunday to Saturday, 21 compartments had multiple pills inside.

In an interview with staff A on at 12:30 who said, she gave resident #2 the medications from the pill organizers.

Resident record review for resident #2 revealed a health assessment report 1823 dated that listed diagnoses of major , , , , and severe memory loss. She needed administration of her medications. The review revealed a notation on the 2017 Medication Observation Record (MOR) that indicated "med/fill 8-1 - " and had initials next to it. The MOR listed the resident's medications and had initials daily.

In an interview with the administrator on at 3:30 PM who said that, the staff gave the resident the medications from the pill organizer and initialed the MOR daily. The resident's husband filled the pill organizer and he made the notation on the MOR. The staff were not nurses but they had taken the 6-hour medication class.

Class III

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

Based on observations, and interview the facility did not make sure when the directions for use of medications were "as needed", the health care provider was contacted and requested to provide revised instructions, that indicated, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for 1 of 4 sampled residents (#2).

Findings:

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Observations during the facility tour on at 9:15 AM noted resident #2 to be asked to see her brother, and called out for brother. Was childlike. Played with building blocks and listened to music.

Observations of the medication for resident #2 on at 1 PM noted a prescription label dated that indicated 0.5 mg daily as needed. The label did not indicate the conditions as to when in was proper for a cognizant resident to request the medication or to allowed a licensed nurse to make a nursing judgment and administered the medication to a resident.

Resident record review for resident #2 revealed a health assessment report 1823 dated that listed diagnoses of major and severe memory loss. She needed administration of her medications.

The 2017 Medication Observation Record (MOR) listed 0.5 mg daily as needed and was marked as given daily from 8/1 to 8/9 at 9AM. Continued review revealed no evidence to confirm revised orders were obtained.

In an interview with the administrator on at 3:30 PM who said the resident was unable to request the medication, as she was . The facility staff gave her the every night. The staff were not nurses.

Class III

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

Based on observations, interviews and record review the facility failed to ensure staff were assigned duties consistent with their qualifications and allowed unlicensed staff to administer medications, conducted sugar testing and to administer medications that required judgment for 2 of 4 sampled residents (#4 and #2)

Findings:

1. Resident record review for resident #4 revealed a health assessment report dated that listed , , high , , , and . She needed assistance with self-administration of medications. She needed thick liquids and soft foods; and was under the care of hospice.

A healthcare provider order dated indicated check at 9 PM before giving

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Lorsatan and , , and to hold them if , , (first number) was equal or less than 110. "When you hold a med (medication), please circle on the list", check , on left arm. Continue sugars before meals and bedtime-record it. Hold , if sugar was less than or equal to 60 or if equal or greater than 400. Any urgency in the middle of the night call hospice.

A healthcare provider order dated indicated check sugars before breakfast and before dinner. Medications may be crushed.

An undated Medication Observation Record (MOR) listed Lorsatan and , and indicated hold them if , , (first number) was equal or less than 110 and had staff initials for the first to the 14 that of that month and indicated held on the 3rd, and the 13th.

In an interview with the administrator on at 3:30 PM, who said that the staff (unlicensed) took the , and did the sugars because they were certified, not unlicensed.

2. Observations on the medication cabinet noted resident #2 had 6 pill organizers. Each compartment was dated from 1 to 31 and Sunday to Saturday, 21 compartments had multiple pills inside. A prescription label dated indicated , 0.5 mg daily as needed

Resident record review for resident #2 revealed a health assessment report 1823 dated that listed diagnoses of major , , , , and severe memory loss. She needed administration of medications. The review revealed a notation on the 2017 MOR that indicated "med/fill 8-1 - " and had initials next to it. The MOR listed the resident's medications and had initials daily.
The MOR listed , 0.5 mg daily as needed and was marked as given daily from 8/1 to 8/9 at 9AM.

In an interview with the administrator on at 3:30 PM who said that, the staff gave the resident the medications from the pill organizer and initialed the MOR daily. The resident's husband filled the pill organizer and he made the notation on the MOR as to when he filled the organizer.

Class III

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

Based on observations, record review and interview the facility failed to ensure that 4 of 4 sampled resident records (#1, #2, #3, and #4) contained all the required components.

Findings:

Individual resident record review for residents # 1, 2, 3, and 4 revealed no evidence to confirm they received an informed consent regarding the provision of assistance with self-administration of medication from unlicensed (not a licensed nurse) and whether or not the unlicensed staff who provided the assistance would or not be supervised by a nurse.

1. Resident #1 received assistance with self-administration of medications from unlicensed staff. Observations during the medication pass on at 12:30 PM noted staff A assisted resident #1 with the medications

2. Resident #2 had a health assessment dated . . . . that indicated she needed administration of medication.

3. Resident #3 had a health assessment dated that indicated she needed assistance with self-administration of medication. Continued record review for resident #3 revealed she was admitted on and needed assistance with activities of daily living. The continued review revealed that an admission weight was not available.

4. Resident #4 had a health assessment dated . . . . that indicated she needed assistance with self-administration of medication.

In an interview with the administrator on at 3:30 PM who said that the staff were certified to pass medications, they were not "unlicensed".

Class III

0167 - Resident Contracts - 58A-5.025 FAC

Based on record review and interview the facility failed to ensure 4 of 4 sampled resident's contracts had all the required information for 4 of 4 resident contracts reviewed (#1, #2, #3 & #4).

Findings:

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Individual resident record review for residents #1, #2, #3, and #4 revealed the contract did not contain the following required information:

1. A provision stating that at least 30 days written notice will be given before any rate increase.

2. The purpose of any advance payments or deposit payments, and the refund policy for such advance or deposit payments.

3. A refund policy that must conform to Section 429.24(3), F.S.;

The contract must include a refund policy to be implemented at the time of a resident's transfer, discharge, or . The refund policy must provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. For the purpose of this paragraph, the termination date shall be the date the unit is vacated by the resident and cleared of all personal belongings. If the amount of belongings does not preclude renting the unit, the facility may clear the unit and charge the resident or his or her estate for moving and storing the items at a rate equal to the actual cost to the facility, not to exceed 20 percent of the regular rate for the unit, provided that 14 days' advance written notification is given. If the resident's possessions are not claimed within 45 days after notification, the facility may dispose of them.

The contract must also specify any other conditions under which claims will be made against the refund due the resident. Except in the case of or a discharge due to medical reasons, the refunds shall be computed in accordance with the notice of relocation requirements specified in the contract.

A resident may not be required to provide the licensee with more than 30 days' notice of termination.

If after a contract is terminated, if the facility intend to make a claim against a refund due the resident, the facility must notify the resident or responsible party in writing of the claim and must provide said party with a reasonable time period of no less than 14 calendar days to respond. The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident.

A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or

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facility. The resident or responsible party must notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident's medical condition prevents the resident from giving written notification, such as when a resident is comatose, and the resident does not have a responsible party to act on the resident's behalf;

A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those that the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, must be notified in writing that the resident must make arrangements for transfer to a care setting that is able to provide services needed by the resident. In the event the resident has no one to represent him or her, the facility must refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions outlined in Section 429.26(8), F.S., will take effect.

At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian must be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

The review revealed a provision in the resident contract that indicated terminations by nuisance: a 3 day notice would be given.

In an interview on at 3:30 PM with the administrator, who stated her contract was reviewed during her initial survey and was found to meet the requirement.

Class III