STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966084	12/06/2017
NAME OF PROVIDER OR SUPPLIER **TITUSVILLE TOWERS**	STREET ADDRESS, CITY, STATE, ZIP CODE **405 INDIAN RIVER AVENUE** **TITUSVILLE, FL 32796**	

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

0000 - Initial Comments

Complaint Investigation #2017011119 was conducted on , 2017. Titusville Towers Assisted Living Facility, License #10346, had deficiencies at the time of the investigation.

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

Based on record review and interview, the facility retained 1 of 27 sampled residents who exceeded the continued residency criteria in an Assisted Living Facility (#4).

Findings:

Resident #4's record revealed he was admitted to the facility on . Health assessment form 1823, dated and signed by a health care provider, indicated that resident #4 had a communicable which could be transmitted to other residents or staff, which exceeded the continued residency criteria.

On at 11:30 a.m., licensed practical nurse (LPN) B confirmed the finding and said the question on the form was answered incorrectly by the health care provider.

The record for resident #4 did not contain documented evidence to indicate the facility discussed the error with the health care provider.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations, record reviews and interviews, the facility failed to follow their smoking policy to ensure an environment free of fire hazards was maintained for 3 of 27 sampled residents (#4, 8 & 9).

Findings:

1. Observations made of resident #4 on at 9:50 a.m. revealed he was sitting in a cloth chair in his . He was smoking a cigarette and flicked the ashes into a trash can located next to his chair. The trash can was filled with paper. Cigarette ashes were observed on the floor and furniture. In addition, the floor was cluttered with Styrofoam containers and food. There were two bottles of drinking on the floor next to the trash can.

Resident #4's record revealed a communication note addressed to a health care provider that indicated

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on , he was walking around the facility naked. He was smoking throughout the building after several attempts were made to redirect him to the smoking area. He was drinking tea in a cup that was filled with cigarette butts. He appeared very . All of the stove burners in his turned on to light his cigarettes. He went to the store on a previous day and purchased Vodka. Staff was unable to tell if he was drunk.

Review of the facility's smoking policy revealed that on , resident #4 signed the policy. The policy indicated that smoking was prohibited in any interior area of the facility, including all living units. A courtesy notice would be given for an unconfirmed lease violation and/or an apparent minor first time violation. If a second violation of the policy occurred, it would result in a "notice for cause."

The record for resident #4 did not contain any documented evidence to indicate he was given a notice when he violated the smoking policy.

On at 11:20 a.m., licensed practical nurse (LPN) B said since resident #4 signed the smoking policy on , she observed him smoking in the facility. His health care provider was kept informed by the facility staff of his drinking of and his smoking. The staff had to continuously remind him to smoke only in the designated smoking areas.

On at 11:35 a.m., resident #4 said other than the smoking policy that he signed on , the facility had not given him any notices regarding non-compliance with the policy.

On at 11:51 a.m., housekeeping supervisor A said resident #4 continuously smokes in his , everyone was aware of it, and he is continuously told not to smoke in his . However, he becomes argumentative. Every month when she delivered the rent statements, she reminded him to smoke in the designated smoking areas.

On at 2:45 p.m., the facility social worker provided a list of residents who she identified as those who smoked. Residents #8 and #9 were on the list.

2. Observations made of the resident #8 on at 3:05 p.m. revealed cigarette butts next to a recliner chair and a hole in the arm rest of the chair.

3. Observations made of the resident #9 on at 3:18 p.m. revealed cigarette butts on a table that contained marks.

The facility's failure to follow and enforce their smoking policy placed the residents at risk for injuries

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related to the fire hazards present in the facility.

Class II