| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968404 | 06/12/2018 |
| NAME OF PROVIDER OR SUPPLIER<br>**DAISY ASSISTED LIVING, LLC.** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**302 BORDEAUX AVE NE**<br>**PALM BAY, FL 32909** | |

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

**0000 - Initial Comments**

A Complaint investigation #2018008632 was conducted on . . . . . Daisy Assisted Living, license #12276, had deficiencies at the time of the visit.

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

Based on observation, record reviews, and interview, the facility retained 1 of 3 sampled residents (#1) who exceeded the continued residency criteria in an Assisted Living Facility (ALF.)

Findings:

Review of the facility's profile on the Florida health finder website revealed the facility held a standard license.

On at 7:15 AM, resident #1 was observed sitting in a wheelchair at the dining table. The resident responded to a greeting, said hello and ate his breakfast independently.

Resident #1's record revealed a facility admission date of . . . . . A health assessment form 1823, dated on , indicated the resident required total assistance with ambulation, toileting and transferring. The 1823 documented he was non-ambulatory.

On . . . . . at 8:30 AM, the administrator confirmed resident #1 could not walk at all. She said he used to use a walker, but does not any more. She is able to help him in and out of bed.

Class III

**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 provide the required 45-day notice of discharge to 3 of 3 sampled residents, and gave less than a 24-hour notice to family members (#1, #2 & #3).

Findings:

Observations during a tour of the facility at 7:15 AM on . . . . . found 3 residents living there. The residents were up, dressed and seated around the dining table. In the dining , there were 3 large,

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clear plastic trash bags of folded clothing on the dining chairs against the wall. When asked, the administrator stated she was just folding laundry last night.

Review of the resident records on found no notices to family members of a planned move.

On at 9:15 AM, the administrator told the surveyor, "I'm having a crisis. I need to go up north for a family emergency. I am putting my residents in respite with another facility (AFCH). That provider came earlier. That is why she came. "She went on to say she "called the families, or texted, something like that," yesterday, to inform them. The administrator said she did not have any staff at this time. She had one person who had worked part time, but her last day was because she was going back to school and could not work. She had no other staff. The administrator said she had a back-up administrator, but she had 2 facilities of her own and could not come work at this facility 24/7 while she was gone.

In interviews with the families and Powers of Attorney for the 3 residents, they each confirmed they only learned of the move on . The wife of resident #3 did not learn of the move until at 10:00 AM. None of the 3 families were informed that their loved ones were being moved out of the assisted living facility (ALF) and into an adult family care home. The administrator stated on at 9:45 AM that she did not know the other facility was not an ALF.

Class III

**0054 - Medication - Records - 58A-5.0185(5) FAC**

Based on observation, Medication Observation Record (MOR review and interview the facility failed to maintain an accurate and up-to-date MOR for 1 of 1 sampled resident (#3).

Findings:

Observation of the medication pass for resident #3 on at 8:15 AM revealed the administrator unlocked and removed the medications for resident #3 and brought them to him at the dining table, along with a paper MOR. She assisted him with self-administrator of his medications, signed the MOR, brought the medications back to the locker, and secured the lock.

Review of the MOR and medication basket for resident #3 revealed the administrator used an electronic MOR most of the time, but she said it was down since last night ( ) and she was using the pre-printed blank MORs instead. The medications provided to resident #3 on the morning of were signed off

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on one page of the 2018 MOR reviewed. The administrator had signed off all doses for the month of to the present, even though she said they were documented on the electronic MOR until . Some meds were not on the MOR for . There were paper MORs dated , 2018 that included the medication missing for . The administrator had signed off , 1-14 as doses given and told me those were for .

When asked why and 14th were already signed, on at 8:25 AM, the administrator said she did not have her glasses on last night and did not see that is was the , MOR and which dates she was signing. She said, "I was trying to make sure everything was up to date in case you (AHCA) came so there weren't any holes."

Class III

**0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC**

Based on observation, facility and resident record review and interview, the facility failed to 1) display the current menu, dated for the week in use, 2) maintain 6 months of menus in file and 3) follow a prescribed therapeutic diet for 1 of 3 sampled residents (#2).

Findings:

Observations during a tour of the facility on at 7:15 AM found a menu posted on the refrigerator. The menu was for week 3 of a 4 week cycle, and was dated for use from -.

Request to review the menus for the past 6 months, found the administrator was not able to locate any menus from to the present.

On at 9:00 AM, the administrator said she did not have any current menus.

Observations of the lunch meal served on at 1:00 PM revealed all 3 residents were served stewed chicken, potato and carrots. Resident #1 was fed her lunch by the provider. The meal was not prepared in a mechanical soft consistency.

Review of the record for resident #2 revealed a mechanical soft therapeutic diet was prescribed on on her health assessment (1823).

On at 2:00 PM, the administrator said she was not aware resident #2 required a mechanical soft

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diet and said she eats the regular meal well.

Class III

**0160 - Records - Facility - 58A-5.024(1) FAC**

Based on observation, facility record review and interview, the facility failed to ensure an accurate and up-to-date Admission and Discharge Log was maintained for 3 of 3 residents (#1, #2 &,#3).

Findings:

Observations during a tour of the facility at 7:15 AM on found 3 residents living there.

Request to review the admission and discharge log was made. The administrator stated she was unable to locate the log and thought that maybe it was at home with some other paperwork.

On at 9:30 AM, the administrator confirmed she did not have an admission-discharge log available for review.

Class III