STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966794	**10/01/2018**
NAME OF PROVIDER OR SUPPLIER **SERENITY LIFESTYLE PLUS, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **490 BRIGHTON AVE NE** **PALM BAY, FL 32907**	

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

0000 - Initial Comments

A Biennial Licensure survey with Limited Nursing Service (LNS) was conducted on . Serenity Lifestyle Plus LLC, License #10937, had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record reviews and interview, the facility failed to ensure an 1823 health assessment form was complete and accurate for 2 of 2 sampled residents (#2 & 3).

Findings:

1. Resident #3's record revealed a facility admission date of . The only 1823 health assessment form, dated , did not contain the address and phone number of the examiner, as required.

2. Resident #2's record revealed a facility admission date of . The only 1823 health assessment form was not dated and pages 2 and 4 of the form were missing. Page 2 of an 1823 form contains information regarding how much assistance is required for Activities of Daily Living (ADLs), diet, whether the resident's needs could be met in an Assisted Living Facility (ALF), and whether any of the following conditions were present: a communicable , bedridden, the presense of a , 3 or 4 , , posed a danger to self or others and required 24-hour nursing or , care. Page 4 of an 1823 contains information as to whether the resident requires assistance with medications and how much assistance is required. A list of medications was attached to the form.

On at 2:55 p.m., caregiver A confirmed the findings and was unable to provide additional information.

Class III

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

Based on record reviews and interview, the facility failed to follow orders from a health care provider for 2 of 2 sampled residents (#2 & 3), and failed to notify a health care provider when 1 of 2 sampled residents had a change in condition (#3).

Findings:

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SUMMARY STATEMENT OF DEFICIENCIES
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1. Resident #2's record contained a health care provider's order, dated , for , 50 milligrams (mg.) by every AM and at bedtime for agitation. His , medication observation record (MOR) listed the , and was signed as given daily at 8 AM and 5 PM.

On at 12:54 PM, caregiver A said resident #2's bedtime was 8 PM or later.

On at 3 PM, caregiver A confirmed the , was not being given at resident #2's bedtime, and said the pharmacy made the time error on the MOR.

In addition, the record contained a health care provider's order, dated , for 8.6 mg. 2 tablets by twice daily for , . However, his , MOR indicated that he was to be given only 1 tablet and it was signed as given from through .

On at 3:20 PM, caregiver A confirmed the findings and said the facility would have to get the pharmacy to correct the dose on the MOR.

2. Resident #3's record contained a health care provider's order, dated , for , 10 mg. by at bedtime. However, review of his , MOR revealed the medication was not listed. His record did not contain an order to discontinue the medication.

Resident #3's record contained a facility note, dated , that indicated he seemed to be sleeping at the table during breakfast but on closer assessment he did not respond to verbal or stimuli. He was also drooling and his , were blue. He was transferred to bed at which time he came around and started speaking. His nephew was notified. He went to sleep on and off throughout the morning. The record did not contain documentation to indicate a health care provider was notified of his change in condition.

On at 3:15 PM, caregiver A confirmed the findings and said she was unable to provide an explanation or additional documentation. She said the administrator was unavailable to assist in obtaining additional information.

Class III

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

Based on observations, record reviews and interviews, the facility failed to honor resident rights and physically restrained 1 of 6 sampled residents (#5).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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Findings:

Observations made of resident #5 on at 9:55 AM revealed he was lying in bed, his were closed, his were at the , he did not respond to verbal stimuli and he had removable full padded side rails on his bed. The left side of his bed was also pushed against the wall. A was on his left .

On at 11 AM, the resident's spouse said the resident had a on his left because he thrashes around in the bed and caused to his skin.

His record revealed he had a diagnoses of 's and he received hospice services for the same. The record contained a health care provider's order for full side bed rails, dated and a hospice order, dated , for full padded bed side rails. There was no documentation in the record to indicate the use of the full side rails was reviewed by the resident's physician annually.

The facility's use of a physical posed a risk of injury to the resident.

On at 2:48 PM, caregiver A said resident #5 kept getting stuck in the half rails, so full rails were placed on his bed.

Class II

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observations, record reviews and interview, the facility failed to ensure the unlicensed caregiver, who assisted a resident with medications, followed the correct procedures (A).

Findings:

Observations made during a medication pass for resident #3 on at 2 PM revealed unlicensed caregiver A unlocked a kitchen cabinet and removed some medication packages. While standing at the kitchen counter, she popped out two pills into a cup. She took only the cup of pills to resident #3, who was sitting in the living room, and she poured the pills into his . While she stood there and observed him, he drank some water.

Caregiver A did not take the medication, in its previously dispensed, properly labeled container, from

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966794	10/01/2018

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

where it was stored and bring it to the resident. She did not read the medication label aloud and remove a prescribed amount of medication from the package in the presence of the resident.

She gave the medication to the resident, which is a task she was not permitted to do as an unlicensed caregiver.

On at 2:30 PM, caregiver A confirmed the findings.

Resident #3's 1823 health assessment form, dated , indicated that he required assistance with self-administered medications.

Class III

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

Based on record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) was properly updated for 2 of 2 residents who received assistance with medications (#2 & 3).

Findings:

1. Resident #2's record revealed a facility admission date of . The only 1823 health assessment form in the record did not indicate whether he required assistance with his medications however, the medications listed on his MOR were being signed as given by the staff.

A health care provider's order, dated , indicated that he was to receive / 5-325 milligrams (mg.) 1 tablet by every 6 hours as needed for . The medication was signed as given on and . However, a time the medication was given was not documented on the MOR.

2. Resident #3's record revealed a facility admission date of . The only 1823 in the record, dated , indicated that he required assistance with self-administered medications.

Review of his MOR revealed entries for 1,000 micrograms/milliliter (ml.) injection, inject 1 ml. as directed once a month on the 20th, and , 25 mg. tablet by twice daily.

On , the number 4 was documented for the , and on through the

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SUMMARY STATEMENT OF DEFICIENCIES
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number 4 was documented for every dose of the .

The key on the MOR indicated the number 4 meant "charted in error". The MOR and the resident's record contained additional documented details regarding the findings on the MOR.

On at 3:30 PM, caregiver A confirmed the findings, said she was unable to provide an explanation, and said the administrator was unavailable to assist with the findings.

Class III

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

Based on observations, record reviews and interview, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience allowing unlicensed staff to administer medications to 1 of 6 sampled residents (#3).

Findings:

Observations made during a medication pass for resident #3 on at 2 PM revealed unlicensed caregiver A unlocked a kitchen cabinet and removed some medication packages. While standing at the kitchen counter, she popped out two pills into a cup. She took only the cup of pills to resident #3, who was sitting in the living room, and she poured the pills into his . While she stood there and observed him, he drank some water.

Caregiver A did not take the medication, in its previously dispensed, properly labeled container, from where it was stored and bring it to the resident. She did not read the medication label aloud and remove a prescribed amount of medication from the package in the presence of the resident.

She gave the medication to the resident, which is a task she was not permitted to do as an unlicensed caregiver.

On at 2:30 PM, caregiver A confirmed the findings.

Resident #3's 1823 health assessment form, dated , indicated that he required assistance with self-administered medications.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966794	**10/01/2018**
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SUMMARY STATEMENT OF DEFICIENCIES
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0162 - Records - Resident - 58A-5.024(3) FAC

Based on record reviews and interview, the facility failed to record a semi-annual for 1 of 2 residents (#5) who received assistance with the Activities of Daily Living (ADLs), and failed to ensure the record for 1 of 2 sampled residents (#2) contained a consent form for unlicensed staff to assist residents with self-administered medications.

Findings:

1. Resident #5's record revealed a facility admission date of . His most recent 1823 health assessment form, dated , indicated that he required assistance with his ADLs. His record contained no recorded for the year 2017.

On at 2:53 p.m. caregiver A confirmed the findings and said he was not because he received hospice services.

2. Resident #2's record revealed a facility admission date of and a residency agreement, dated . The record and the agreement did not contain a written copy of the written informed consent allowing unlicensed staff to assist with self-administered medications.

On at 3:30 PM, caregiver A confirmed the finding and said she was unable to provide an explanation and said the administrator was unavailable to assist with the findings.

Class III

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record reviews and interview, the facility failed to ensure the residency agreement for 2 of 2 sampled residents contained a provision stating whether the facility is affiliated with any religious organization and, if so, which organization and its relationship to the facility (#2 & 3).

Findings:

Resident #2's residency agreement was dated .

Resident #3's residency agreement was dated .

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SUMMARY STATEMENT OF DEFICIENCIES
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Both agreements did not contain a provision stating whether the facility is affiliated with any religious organization, as required.

On at 3:30 PM, caregiver A confirmed the findings, said she could not provide an explanation, and said the administrator was not available to assist with the findings.

Class

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on review of florida health finder and interview, the facility failed to acquire an alternate power source such as a generator, maintained at the facility, to ensure the facility will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six hours in the event of the loss of primary electrical power, failed to develop written policies and procedures to ensure the facility can effectively and immediately operate and maintain the alternate power source and any fuel required for the operation of the alternate power source, failed to acquire monoxide alarms and failed to, within five business days, notify in writing each resident and the resident's legal representative upon submission of its emergency environmental control plan to the local emergency management agency that the plan had been submitted for review and approval and when the plan was implemented.

Findings:

Review of the florida health finder website on at 5 PM revealed the facility's emergency power plan was approved by the County and implemented on .

On at 3:54 PM, caregiver A phoned the administrator to discuss the facility's emergency plan with the surveyor. The administrator said although the facility obtained approval from the County for its plan and the facility implemented its plan, the facility had not yet purchased a generator. In addition, she said the required polices and procedures were not developed, monoxide alarms had not been purchased, and the residents and their legal representatives were not notified in writing when the plan was submitted for review and approval and again when it was implemented.

Class III

Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on observations, review of the online Agency background screening website and interviews, the

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	AL11966794	10/01/2018

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SUMMARY STATEMENT OF DEFICIENCIES
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facility failed to have evidence that an individual (visitor) who had access to all of the resident's rooms had an eligible background screening.

Findings:

Upon entrance to the facility on at 9:45 AM, a woman (visitor) answered the front door of the facility and gave her name. She said she arrived to the facility at 7 AM that morning when the administrator left, she did not work at the facility and she was just there until the administrator returned. She said besides the residents, she was the only other person in the facility.

On at 9:55 AM, the visitor was observed in resident #6's bedroom standing at the window that faced the backyard. She waved at someone by who was on the outside in the backyard. Upon going outside, a young female was observed walking around the side of the house from the backyard. An attempt was made to catch up to her but she walked fast down the sidewalk in front of and away from the facility. When asked to stop, she did not respond but rather continued to walk away from the facility. Upon returning inside the facility, the visitor was questioned about who the woman was that she waved at through the window. The visitor initially denied waving at anyone but when confronted with the observations, she said there was a woman walking by the window in the yard who waved at her, so she waved . The visitor then exited the front door of the facility and walked across the street and away from the facility. When asked where she was going, she pointed her across the street and said "just over there". When told she could not leave the residents unattended, she turned around and returned to the facility.

On at 10:05 AM, the administrator arrived to the facility. With the administrator still in the driveway, the visitor exited the front door of the facility and left. She never returned during the survey. The administrator entered the facility, and when questioned regarding the visitor, she said the visitor was caregiver C, who was a caregiver employed by the facility. The name given by the administrator was not the name the visitor said she was upon entrance to the facility.

On at 10:20 AM, review of the Agency's background screening website revealed the picture of caregiver C was not that of the visitor therefore, there was no documentation to indicate the visitor had an eligible background screening.

On at 4 PM, caregiver A was on the phone with the administrator who said she did not know why the visitor identified herself by a different name other than that of caregiver C, and she could not explain the visitor's behavior and actions on that morning.

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