| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968809** | **02/04/2019** |
| NAME OF PROVIDER OR SUPPLIER<br>**ROSE ASSISTED LIVING FACILITY LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**256 SW MOSELLE AVE**<br>**PORT SAINT LUCIE, FL 34984** | |

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

**0000 - Initial Comments**

An unannounced Re-Licensure with Limited Nursing Services (LNS) survey was conducted on at Rose Assisted Living Facility LLC (License #12659). The facility had deficiencies identified at the time of the survey.

Note: The LNS portion of the survey was conducted on a separate date.

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

Based on record review and an interview, the facility failed to ensure "as needed (PRN)" medication listed on the Medication Observation Record (MOR), for 1 out of 3 sampled residents (Resident #1), had specific instructions for use, including the circumstances under which it would be appropriate for the resident to request the medication and any limitations.

The findings included:

On at 12:00 PM, the MOR for Resident #1 was reviewed and listed , , Diskus Inhaler and to be taken "PRN" or "as needed". There were no instructions listed for when the resident was to receive this medication and for what reason.

These findings were discussed with the Administrator at this time. She acknowledged that specific instructions for the use of PRN medications was not listed on the resident's MOR.

Class III

**0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS**

Based on record review and an interview, the facility failed to ensure that 1 out of 2 sampled unlicensed staff members (Staff A) who provided assistance with self-administered medications had successfully completed a minimum of 6 hours initial training on providing assistance with self-administered medications and safe medication practices in an ALF (Assisted Living Facility).

The findings included:

The personnel file for Staff A was reviewed for documentation of a minimum of 6 hours of initial training on providing assistance with self-administered medications and safe medication practices in an ALF.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER<br>**ROSE ASSISTED LIVING FACILITY LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**256 SW MOSELLE AVE**<br>**PORT SAINT LUCIE, FL 34984** | |

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

The last documented training was a course in "Essentials of Medication Administration" completed on , with no hours noted on the certificate. Prior to that, a certificate dated documented completion of a 2 hour course in "Medication Management".

There was no documentation to show completion of the 6 hour initial training in assisting with self-administration of medication, or of a 4 hour initial course with an additional 2 hours of training that focuses on syringes, stockings, bags and vital signs described in 58A-0191(6)(b)2.h.-n., F.A.C. (Florida Administrative Code), effective .

During interview with Staff A on at 11:00 AM, she confirmed that she assisted residents with medication administration and acknowledged the findings on the aforementioned training certificates. The facility provided no additional documentation for review at this time.

Class III

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

Based on record review and interviews, the facility failed to ensure that meal items served with substitutions of equal nutritional value were documented at the time or prior to the meal is served; and, failed to obtain annual approval of the menu by a qualified dietary professional.

The findings included:

On at 12:00 PM, the posted dietician approved menu dated indicated that the residents were to be served the following items for dinner on :

1. Chicken
2. Rice
3. Peas
4. Salad
5. Cake or Pie

During interview with the Administrator at this time, she stated that Lasagna was served for dinner on . She acknowledged that the substitute meal was not documented. She stated she did not have documentation of substituted meal items for the last 6 months as required. Additionally, the posted menu had been approved on by the Registered Dietician. The Adminisrator stated she had not yet received the annual approved menu from the dietician.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER<br>**ROSE ASSISTED LIVING FACILITY LLC** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**256 SW MOSELLE AVE**<br>**PORT SAINT LUCIE, FL 34984** | |

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

The facility provided no additional documentation for review at this time.

Class III

**0181 - Emergency Plan Approval - 58A-5.026(2) FAC**

Based on record review and an interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) to the county timely for their annual approval.

The findings included:

On [redacted] at 10:40 AM, the CEMP approved on [redacted] was reviewed with the Administrator. She stated that the annual approval of the CEMP had not been obtained yet for this plan that expires on [redacted].

On [redacted] at 12:26 PM, a county representative with the Division of Emergency Management stated that the facility's CEMP had not yet been submitted as of this date for their annual approval by the county, and that their current plan is now expired.

Class III