STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968060	**02/11/2019**
NAME OF PROVIDER OR SUPPLIER **EASTSIDE ACTIVE LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1600 TAFT STREET** **HOLLYWOOD, FL 33020**	

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0000 - Initial Comments

AMENDED

An unannounced Relicensure survey commenced on [redacted] and concluded on [redacted] at Eastside Active Living, License #12023. The facility had deficiencies at the time of the survey.

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

Based on record review, interview, and observation, the facility failed to ensure that all residents was reassessed for continued residency after a significant change in health status and that each resident obtained a new Agency for Health Care Administration Health Assessment (AHCA Form 1823) that is current and reflective of the residents care needs, for 2 of 4 sampled residents (Resident #23 and Resident #24).

The findings included:

A. Record Review of the most current 1823 form for Resident #23 dated for revealed that Resident #23 has a medical history and diagnosis of [redacted], frequent , and a history of slip and . The resident is sight , with decline and is noted to be a precaution. Resident #23 requires assistance with all activities of daily living (ADL's) except for eating in which the resident is independent. Further review of the form revealed that the form was never signed or acknowledged Administrator herself for accuracy of the form . The medication list for the resident was also never provided and left blank on the medication list section.

During an interview with Resident #23 on at 11:45 AM, it was stated that I don't know where my [redacted] is and that I have been looking for it and I cant find it anywhere. It was stated that about two days ago I and hit my and went to the hospital. I have not seen my [redacted] since I came . It was further stated that I use it all the time but lately I am trying to slow down using it and that no one comes in and fill it or maintain it. It was also stated that I don't change the water or anything on it because I didn't know I was supposed too and that I need the [redacted] now because I am feeling [redacted]. I have been in the bed the last couple of days because I haven't had enough [redacted] to get up to go anywhere. Observations of the residents private room revealed six empty portable [redacted] tanks under the table.

During an interview with the Facility's Nurse at 11:52 PM on , it was stated that the staff was not aware that the resident was missing her [redacted] and that this is the first time that she had heard

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about it. The staff was unaware if the resident was receiving Home Health services for the and was unaware if anyone has been providing oversite to the resident.

At 3:00 PM on with Surveyor intervention, Resident #23's concentrator was found in the storage room after being cleaned from when the resident on and bumped her on it. The concentrator was never returned to the resident and the resident has been without the since. Had the facility provided the required assistance and supervision needed for Resident #23 with transferring, and ambulation the staff would have known that the resident was not receiving the appropriate care and services needed.

During an interview with the Administrator on at 5:00 PM, the findings were discussed and acknowledged, no further information was provided for review.

B. Observations of Resident #24 walking to the dining room with a rolling walker from the outside of the facility revealed the resident gasping for air with the use of a portable concentrator. Further observations of the resident revealed that the residents were blue in color from depravation. Surveyor Intervention contacted the staff for assistance in grabbing the resident a chair to sit down and catch her breath.

During Interviewed with Resident #24 at 12:30 pm on it was stated that I came to assisted living around from the independent living side. It was stated that I need continuous and that I have an order somewhere but I don't think the facility have it. It was stated that I can monitor it and change it myself, even order the tanks but they said I couldn't have it here. It was stated that I feel like it was a lie because just last week I seen a guy wheeling in a big tank for someone else living here that was put on . It was stated that the facility gave me a 45-day notice that was given on and my family just called saying they just received it. I feel like they are retaliating against me because I know I'm not the only one here with but I feel like I'm the only one that's being discharged. They said that they don't have the license here for me to have , but they took me in a few months ago knowing I needed it. We even went through the ends and out (resident started to tear up and cry).

Review of the 1823 form for Resident #24 dated for with a medical history and diagnosis of . The physical and sensory limitations, or behavioral status, nursing treatment/

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service requirements were all left blank. Special precautions were left blank. The resident requires assistance with all ADL's except for self care and grooming. On the section that asks if the resident requires assistance taking his or her medication was also left blank. The Administrator, the resident or the resident's representative never signed the form acknowledging the information on the form is accurate and correct. The form does not mention that the resident requires at all or how often the is needed. The form was not completely filled out and determined to be inaccurate of the residents current care needs.

During an interview with the Administrator at 5:00 PM on regarding the appropriateness of the resident it was stated by the Administrator that I assessed the resident myself and told her that we cannot take her if she needs all the time because we do not have the license for it. The Administrator was informed that the resident needs and the facility admitted the resident without making the determination if Resident #24's care needs could have been met. The 1823 form was handed to the Administrator for review. The findings were discussed and acknowledged during this time, no further information was provided for review.

Class III

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

Based on record review and observation, the facility failed to sign the Medication Observation Record (MOR), immediately after assisting with self-administration of medication for 12 of 21 sampled residents (Resident#1, #9, #21, #23, #24, #25, #26, #27, #28, #29, #30, and #32).

The findings Included:

Random audit of the MOR's on for 21 sampled medication observations revealed that 12 of the residents (Resident #1, Resident #9, Resident #21, Resident #23, Resident #24, Resident #25, Resident #26, Resident #27, Resident #28, Resident #29, Resident #30, and Resident #32) observed had medications that were not signed off for given immediately after the assistance for self-administration of medication process. Further observations of the MOR's revealed the same findings for the months of and for one or more days.

Confidential resident interviews on and between the times of 9:00 AM and 5:00 PM

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revealed that on some days medications are not given, or are delayed due to the staff not ordering the medications timely.

During an interview with the LPN and the Administrator on at 4:30 PM it was stated by the LPN that I have only been here for two weeks and that I do not know what happened prior to me working here. The Administrator stated that I was unaware that the Staff were not signing the MORs and that the residents never told me any of these things. During this time, the findings were discussed and acknowledged, no further information was provided for review.

Class III

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

Based on records review and interview, the facility failed to ensure that Residents' medications were ordered timely as reported by residents during interviews and as evidenced by annotation on the Medication Observation Records (MOR) that residents' medications were not available during the time assistance was provided to 8 of 23 sampled Residents (Residents #3, 4, 16, 17, 18, 19, 20, 21) to take their medications.

The findings included:

On from 10 AM to 1:00 PM while conducting interviews with multiple sample residents, it was reported and documented that the facility had a systemic problem of ordering residents' medications late. The residents reported that they regularly miss their medications because they were not ordered on time. Review of the MORs on confirmed that medications were not being refilled timely.

It was noted that: Resident #17, # #19,#20, #21, and #22 had from to multiple medications that were not available (the note on the MOR revealed the facility was waiting for their delivery (photographic evidence enclosed).

During an interview with the Nurse on at about 3:00 PM, she indicated that she was rather new to her position and that she was not aware of this problem. She ensured that she will address that problem.

During a follow-up interview with the Administrator on at 3:00 PM, she provided no additional information.

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Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on record review and an interview, the facility failed to ensure that 3 out of 4 sampled employees (Employees B C and D) who provide direct care to residents received the required in-service training within 30 days of employment.

The findings included:

Review of Employee B's personnel file revealed a hire date of and Employee D a hire date of . However, further review showed there was no evidence that Employee B and D had completed trainings in Elopement, incident reporting, Nutritional and safe food handling. In addition, there was no evidence of Residents' Right training for Employee D.

During an interview with the Administrator on at 3:00 PM, she confirmed that Employee B and D are current of employees of the facility but failed to provide proof that the aforementioned trainings were completed.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and an interview, the facility failed to ensure that 2 out of 4 sampled employees (Employees B and D) who provide direct care to residents received the required in-service trainings within 30 days of employment.

The findings included:

Review of Employee B's personnel file revealed a hire date of and Employee D a hire date of . However, further review showed there was no evidence that Employee B and D had completed training in the facility's ( ) Policy and Procedures.

During an interview with the Administrator on at 3:00 PM, she confirmed that Employee B and

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D are current of employees of the facility but failed to provide proof that the aforementioned trainings were completed.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on Observation, record review and interview the facility failed to maintain an alternate power source (generator) on site with sufficient fuel to operate the alternate power source as evidenced by failing to provide care and services needed for all sampled residents residing at the facility. The facility also failed to ensure that air temperatures will be maintained at or below 81 degrees Fahrenheit in the event of the loss of primary electrical power.

The findings included:

A generator assessment was conducted on and that revealed that the facility has a fixed generator stored onsite that is not installed and is sitting on the property.

Confidential interviews with residents and staff on and between the times of 9:00 AM and 5:00 PM revealed that on the weekend of inclement weather hit and that the power in the facility went completely out leaving nothing operating except a few up lights on the assisted living side of the facility. It was stated that the power went out between the time of 6 pm and came on no later than 6 am the following morning. It was stated that during this time the facility was without flashlights or any emergency equipment, and that the maintenance staff in charge in the event of an emergency was unavailable. The staff was unaware of what to do or who to call, and that the residents that required in the facility was unable to obtain this service.

During an interview with the Administrator, the Owner and the Business Office Manager (BOM) on at 1:00 PM it was confirmed that the power at the facility did go out during this time and it was revealed that the facility is waiting for city permits and fire approval to install the current generator sitting on site and that the facility have a contract to rent a generator if one is needed and the power goes out.

Review of the contract the BOM provided from "Confidential Company" stated that the proposed rental period for the 2019 hurricane season is for until , and that the customer may elect to have the generator delivered at the proposed rental agreement period. Further

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review of the contract revealed that the company will deliver the generator within 24 hours of the customer's request with 250 gallons of fuel as that is the maximum amount the "Confidential Agency" will allow to be transported safely (the Generator needs at least 500 gallons to operate).

It was further stated in the contract that in the event of a disaster that may cause logistical difficulties with transportation "Confidential Company" is not liable for delivery until such a time that the delivery of the equipment can be made without harm to the equipment or the personnel leaving residents inside the facility and without if needed until a time in which someone calls the generator company, and the company confirms they are able to deliver the generator in a designated time frame.

In the event of an emergency or primary loss of electrical power the facility does not have an alternate power source available immediately to accommodate the care and services needed for their residents. The contract for the generator rental only covers 6 months out of a 12 month year pending the driving conditions is safe for transport for the equipment and the personnel. The facility does not have a designated person on site to operate the generator or obtain the fuel when the maintenance director is unavailable. The facility does not have anything in writing given to the residents or the residents representatives or anything in writing that instructs the staff on how to operate the generator if the maintenance personnel is unavailable. There is no alternative plan in place until the rented equipment become available to ensure the residents and staff remain cool and temperatures inside the facility remain below 81 degrees Fahrenheit.

During an interview with the Administrator and the Facility's Nurse on at 12:00 PM, the findings were discussed and acknowledged, no further information was provided for review.

Class III

L241 - LMH - Records - 429.075( ); 58A-5.029(2) FAC

Based on observations, interviews and record review, the facility failed to maintain an up-to date admission and discharge log that clearly identifies all limited mental health (LMH) residents and ensure that each Limited Mental Health resident has on file a community living support plan (CLSP) or , agreement for 3 of 3 sampled LMH residents residing at the facility (Resident #1, Resident #5, and Resident #9).

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The findings included:

While requesting to review the facility's Admission and Discharge log on [redacted] for LMH criteria the Admission and Discharge log was never provided. Review of the files for Resident #1, Resident #5, and Resident #9 revealed no documentation of the Community Living Support Plan or [redacted] Agreement for any of the residents identified as LMH.

During an interview with the Administrator on [redacted] at 4:00 pm, the Administrator was unaware of where the Admission and Discharge log was located, unaware of the qualifications for LMH, and unaware of what the CLSP was or that it should be included in the file. After surveyor intervention the Limited Mental Health Criteria was explained. The findings were discussed and acknowledged, no further information was provided for review.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(9) FAC

Based on records review and interview, it was determined that four sampled employees (Employees A, B, C and D) had not completed the required Limited Mental Health (LMH) training within six months of hire, as mandated for facilities licensed to provide limited mental health services.

The findings included:

On [redacted] during review of the Employees' record, it was noted that Employee A (the Administrator) and Employees B, C and D hired on [redacted] ; [redacted] ; [redacted] and [redacted] respectively had either partially completed the Limited Mental Health training, or not at all.

The Administrator or Employee A only hired on [redacted] and promoted as Administrator on 11/4/2018 only completed 3 hours of LMH training on [redacted].

Employees B and C have not received the LMH training and Employee D completed 2 hours of LMH training on [redacted].

During an interview with the Administrator on [redacted] at 3:00 PM, she was unable to provide contrary

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evidence to the findings. She therefore acknowledged and agreed with the findings.

Class III

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on records review and interview, the facility failed to ensure that 4 out of sampled Employees (the Administrator, Employee B, C & D) had a Background Screening compliance Attestation in their records.

The findings included:

During employees' files review on , it was noted that the following employees (Administrator, Employee B, C, & D) hired on , , and respectively had no evidence of having completed the Background Screening Compliance attestation. The document was not in their records.

During an interview with the Administrator and the facility's nurse on at around 3:10 PM, they indicated having no knowledge of such records. The Administrator provided no additional information during the exit.

Class III