

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969028	(X3) DATE SURVEY COMPLETED 04/25/2019
NAME OF PROVIDER OR SUPPLIER ZON BEACHSIDE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
0000 - Initial Comments An Extended Congregate Care (ECC) monitoring visit was conducted at Zon Beachside Assisted Living Facility on Deficiencies were identified 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 (#1 and #2). Findings: 1. Resident #1's record revealed a facility admission date of An undated 1823 indicated that she required total assistance with bathing, . . . , grooming, toileting, and transferring, it did not contain the examiner's address and telephone number, was not answered as to whether she required assistance with medications, and page 5 was not completed. The record did not contain documentation to indicate the facility contacted a health care provider to obtain the omitted information. On at 2:15 p.m. both the director of nursing and assistant executive director confirmed the findings on the 1823 and said the resident never required total assistance with her Activities of Daily Living (ADLs.) Observations made of resident #1 at 2:35 p.m. revealed she was independently mobile. She said she was independent with . . . , grooming, toileting, and transferring and she received assistance only with bathing. At 2:39 p.m. caregiver E said resident #1 was independent with her ADLs and she received assistance only with bathing. At 2:40 p.m. caregiver F also said the resident was independent with her ADLs and received assistance only with bathing. Therefore, the 1823 was inaccurate. 2. Resident #2's record revealed a facility admission date of A current 1823, dated ,		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/20/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969028	(X3) DATE SURVEY COMPLETED 04/25/2019
---------------------------	---	---

NAME OF PROVIDER OR SUPPLIER ZON BEACHSIDE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937
--	---

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

was missing the printed name, address, telephone, and title of the examiner and was not answered as to whether he required assistance with medication.

The record did not contain documentation to indicate the facility contacted a health care provider to obtain the omitted information.

At 2:20 p.m. both the director of nursing and assistant executive director confirmed the findings.

Class III

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

Based on personnel record reviews and interview, the facility failed to ensure the personnel record for 1 of 4 sampled staff (D) contained documented evidence of a negative () exam on an annual basis.

Findings:

Nurse D was hired on Her personnel record contained an updated written statement from a health care provider documenting freedom from communicable, dated The record did not contain documented evidence of a negative . . . exam for 2019, as required.

On at 4:05 p.m. nurse D confirmed the findings and said she did not have a . . . exam this year.

Class III

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

Based on personnel record reviews and interview, the facility failed to ensure that 2 of 4 sampled staff (B and C) received the required in-service training as described in 58A-5.0191() FAC.

Findings:

Caregiver B was hired on

Caregiver C was hired on

Caregiver B's record contained a 2 hour preservice orientation training certificate, dated, and

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969028	(X3) DATE SURVEY COMPLETED 04/25/2019
NAME OF PROVIDER OR SUPPLIER ZON BEACHSIDE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
caregiver C's record contained one dated "" Both certificates were signed only by the director of nursing, their records did not contain a written statement signed by the administrator and employee indicating they each received the preservice training, and the training agenda did not contain the topics of resident rights and the facility license type and services offered by the facility . In addition, caregiver C's record did not contain documented evidence to indicate she received in-service training regarding the facility's resident elopement response policies and procedures but rather a certificate of training, dated, was titled "elopement drill" with a subject matter of "participation in elopement drill." Neither record contained documented evidence to indicate either caregiver was core trained to exclude them from receiving the required preservice orientation. On at 4:05 p.m. the assistant executive director confirmed the findings. Photographic evidence obtained. Class III E206 - ECC - Service Plans - 58A-5.030(6) FAC Based on record reviews and interviews, the facility failed to develop a preliminary service plan that included an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs and within 14 days of receiving services coordinate the development of a written service plan that takes into account the resident's health assessment, the resident's unique physical, and social needs and preferences, and how the facility will meet the resident's needs for 2 of 2 sampled residents (#1 and #2) who received an Extended Congregate Care (ECC) service and failed to ensure an ECC service plan was developed and agreed upon by the resident or the resident's representative for 1 of 2 sampled residents (#2.) Findings: The facility holds an ECC specialty license. On at 12:30 p.m. the assistant executive director said there were no residents who received an ECC service.		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/20/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969028	(X3) DATE SURVEY COMPLETED 04/25/2019
NAME OF PROVIDER OR SUPPLIER ZON BEACHSIDE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
On at 1:20 p.m. nurse A said she performed care on resident #1 for a on her and changed the every 3 days and said she assisted resident #2 with an by performing care every morning and flushing the as needed, all of which are ECC services. 1. Resident #1's record revealed a facility admission date of On the facility notified a health care provider that the resident sustained a on her left lower extremity, approximately 2 x 2 inches. The provider ordered for the to be cleansed with cleanser, dry, apply steri-strips and triple cover with Telfa, wrap with kling every 3 days until healed, keep steri-strips intact, and monitor for signs and symptoms of The resident's Medication Observation Record contained the treatment order and was signed as completed on and The resident's record did not contain ECC preliminary and written service plans, as required. 2. Resident #2's record revealed a facility admission date of He was admitted with an A health care provider's order, dated, instructed to change his and irrigate it with 100 milliliters (ml) of, both as needed. His MOR contained an entry for daily care and was signed as completed from through A nurse's note, dated, indicated the nurse flushed his with 80 ml of sterile The director of nursing provided only one ECC service plan that was dated however, there was no documentation to indicate the plan was developed and agreed upon by the resident or the resident's representative, as required. On at 2:15 p.m. the director of nursing confirmed the findings and was unable to provide additional documentation. Photographic evidence obtained.		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969028	(X3) DATE SURVEY COMPLETED 04/25/2019
NAME OF PROVIDER OR SUPPLIER ZON BEACHSIDE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
Class III E207 - ECC - Services - 58A-5.030(7) FAC Based on record reviews and interviews, the facility failed to ensure nursing progress notes were maintained for 2 of 2 sampled residents (#1 and #2) who received an Extended Congregate Care (ECC) service and failed to ensure a nursing assessment was conducted at least monthly for 1 of 2 sampled residents (#2.) Findings: The facility holds an ECC specialty license. On [redacted] at 12:30 p.m. the assistant executive director said there were no residents who received an ECC service. On [redacted] at 1:20 p.m. nurse A said she performed [redacted] care on resident #1 for a [redacted] on her [redacted] and changed the [redacted] every 3 days and said she assisted resident #2 with an [redacted] by performing [redacted] care every morning and flushing the [redacted] as needed, all of which are ECC services. 1. Resident #1's record revealed a facility admission date of [redacted]. On [redacted] the facility notified a health care provider that the resident sustained a [redacted] on her left lower extremity, approximately 2 x 2 inches. The provider ordered for the [redacted] to be cleansed with [redacted] cleanser, [redacted] dry, apply steri-strips and triple [redacted], cover with Telfa, wrap with kling every 3 days until healed, keep steri-strips intact, and monitor for signs and symptoms of [redacted]. The resident's [redacted] Medication Observation Record contained the treatment order and was signed as completed on [redacted], and [redacted]. The treatment was discontinued on [redacted], the day of the monitoring visit. The resident's record did not contain a nursing progress note each time [redacted] care was provided, as required. 2. Resident #2's record revealed a facility admission date of [redacted]. He was admitted with an [redacted].		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/20/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969028	(X3) DATE SURVEY COMPLETED 04/25/2019
NAME OF PROVIDER OR SUPPLIER ZON BEACHSIDE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
A health care provider's order, dated 04/25/2019, instructed to change his dressing and irrigate it with 100 milliliters (ml) of 0.9% NaCl, both as needed. His 04/25/2019 MOR contained an entry for daily wound care and was signed as completed from 0800 through 1800. The resident's record did not contain nursing progress notes on 04/25/2019 and did not contain monthly nursing assessments, as required. On 04/25/2019 at 2:15 p.m. the director of nursing confirmed the findings and was unable to provide additional documentation. Photographic evidence obtained. Class III		