Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964922	A. BUILDING: _____ B. WING _____	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF PALM BEACH	4760 JOG ROAD GREENACRES, FL 33467

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced licensure complaint survey, Complaint Number 2019007862, was conducted on though at Pacifica Senior Living of Palm Beach. The facility had deficiencies at the time of the survey.	A 000		
A 008 SS=D	429.26( ) FS; 58A-5.0181(2) FAC Admissions - Health Assessment 429.26 (4) If possible, each resident shall have been examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission.	A 008		

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A 008	Continued From page 1 The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request. (6) Any resident accepted in a facility and placed by the department or the Department of Children and Families shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the	A 008		

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A 008	Continued From page 2 operator whom to call should problems arise. The applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of , require such assistance. 58A-5.0181 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , or any other communicable , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name,	A 008		

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A 008	Continued From page 3 signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by	A 008		

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A 008	Continued From page 4 the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or . (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that 1 of 3 sampled residents' (Resident #2) health assessment	A 008		

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A 008	Continued From page 5 (AHCA form 1823) was completed accurately and throughly. The findings included: On at 8:00 AM during medication review, it was observed that one of the facility's licensed practical nurse (LPN) was in the med-room when Resident #2's Private Duty Aide (PDA) arrived and requested the resident's medications. The Nurse retrieved the prescribed medication packages, she pushed the pills into a plastic cup and handed them to the PDA who went to Resident #2's room with the pills. This writer immediately followed the PDA to the room. After entering the room, the PDA was observed taking a small spoon and fed the pills to Resident #2, then she handed Resident #2 a cup of water. Resident #2 swallowed the pills with the water. Review of Resident #2's health assessment (AHCA Form 1823) dated . . . . . provided no direction regarding the assistance level required by Resident #2 for administration of medications. There was no indication in section B of the form that Resident #2 was able to self-administer medications or needed medications administration. The choices were left blank. In section I of the form, it was noted that Resident #2 suffered from , , 's . . . . . and . . . . . Further review of Resident #2's file, revealed another health assessment completed by the facility and dated that indicated that Resident #2 self-directed medication administration. But the form was completed by the facility's nurse. During an interview with the Administrator on	A 008		

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A 008	Continued From page 6 . . . . . at 12:00 PM, she provided no additional information. Class III	A 008		
A 010 SS=D	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (9) A . . . . , ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of	A 010		

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A 010	Continued From page 7 the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions	A 010		

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A 010	Continued From page 8 are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to reassess a resident after the resident exhibited significant behavior changes to ensure that the resident was appropriate for continued residency and that the facility could meet the care	A 010		

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A 010	Continued From page 9 needs of the resident (including supervision), for 1 out of 3 sampled residents (Resident #1). The facility also failed to document the findings of the assessment on a new Resident Health Assessment form (AHCA form 1823). The findings included: On . . . . . at 9:00 AM, during a tour in the courtyard of Cottage #1 and #2, it was observed and noted that Resident #1 was outside, while an Private Aide was trying to encourage him to go inside the facility. Resident #1 sat on the bench and did not want to go inside. On at 10:14 AM, during a meeting with the Executive Director, she reported that she has been receiving multiple complaints from Resident #2's family member recently regarding Resident #1's behavior and ˇ into Resident #2's room; exhibiting touching and grabbing behavior towards individual (including residents). She further stated that the Family member has made a remark to the nurse indicating that she was okay with the other residents . . . ˇ in her mother's room, but this , resident was different, that he is {skin tone identified}. The Nurse present during the interview reported that the family member's complaints were racially motivated. During an interview with Employee (I) on . . . . . at 11:59 AM, she reported that she assists with activities. She said that Resident #1 . . . . around and likes staying outside. He also exhibits PICA behaviors. Resident#1 requires redirection from time to time. She has been told that Resident #1 into other residents' rooms, but she has not witnessed such behavior. She said that Resident #1 is not	A 010		

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A 010	Continued From page 10	A 010		

aggressive and to her "he is a sweetheart". She said the resident is helpful and tries to open up the doors for other residents but that act and other behaviors might be misinterpreted due to a lack of communication. She indicated that Resident #1 is non-verbal, he "mumbles" his words.

During an interview with one of Resident #1's PDA on at 12:19 PM, she reported that she works three days a week from 11 AM to 11 PM. She said that she is hired by an agency. She said that the Resident #1 is very nice. When she arrived to work today, Resident #1 was happy when he saw her and was so happy that he gave her a hug; because, she cared for him once before. She reported that Resident #1 puts everything in his . Consequently, they have to keep the bathroom's door closed so that Resident #1 does not drink water from the sink or eat things from the bathroom. They also keep his closet doors closed. The resident was observed wearing a jumper suit. The PDA explained and said that it was because Resident #1 would remove his clothes, if they put shirt and pants on him, to put them in his . She said that he acts like a child. Resident #1 was observed in bed laying down.

On at 12:39 PM, during a confidential family interview, the following was revealed. They observed Resident #1 walking into their mother's room and trying to go into the mother's bed. The family members reported that Resident #1 was acting like a child, but he was strong. One of the members said when she tried to redirect Resident #1, she quickly realized that the task was going to be a challenge for her. So, she called for help and the facility staff came right away and they were able to redirect Resident #1 without any problem.

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A 010	Continued From page 11 She said that the staff is very caring. However, she was not sure whether Resident #1 was appropriate for this unit. It was also revealed that Resident #1 placed his on his a couple of times but, he was able to redirect him. He said "man can tolerate that behavior but the ladies not so much". They indicated that Resident #1 had no one supervising him at that time. On at 10:56 AM, Resident # 1's PDA reported that on , she worked one week and half week with Resident #1. She indicated that there was another man who also worked with Resident #1 during the night of . The PDA reported that Resident #1 requires total care for all ADLs, and he also requires medication administration. Resident #1 cannot feed himself, he would dirty all his clothes and , she said. In order words, he requires higher level of care. The PDA reported that the night worker told her that Resident #1 did not sleep at all, the night before. On at 11:00 AM Resident #2's PDA reported that she has been working with Resident #2 for a long time. She stated that she is a licensed practical nurse (LPN). She said that on multiple occasions Resident #1 was left unsupervised and he eventually went into other residents' rooms. She said that they used to place the meals on the counter before serving them to the residents, and Resident #1 would grab them and eat them and create a total mess. She said, that is why they now place the meals on a table cloth on the counter as observed, so that they can have time to pull all of them away at the same time in case Resident #1 would be near the counter. She explained when the staff stands inside the kitchen preparing the meals, they would not have time to refrain Resident #1 from	A 010		

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A 010	Continued From page 12	A 010		

reaching out for the foods on the counter. She also reported that she can understand Resident #1 and grabbing things, but the problem is that they are not supervising him and think that his behavior is acceptable. She said that she is used to residents and patients grabbing body parts all the time, but the behavior is not acceptable. She indicated that Resident #1 does not know what he is doing. He is not aggressive, but he invades others' privacy.

On at 1:06 PM, Resident #2's daughter's confirmed numerous problems regarding Resident #1's behavior of , entering various resident's rooms (including Resident #2). It was also revealed that the Administrator was informed on numerous occasions of the concerns.

On at 2:32 PM, during an interview with Resident #2 and her husband, Resident #2 reported in a shallow sounded voice that there are serious concerns of lack of monitoring of Resident #1. Resident #2 said that she was definitely afraid of Resident #1. She said that Resident #1 came to the room and tried to get into her bed. She does not appreciate that. The husband however indicated that he had not witnessed the resident being aggressive. He said that he understands that it is not Resident #1's fault, but it is wrong that the Administration has not provided the level of supervision that Resident #1 requires.

Review of the Nurses' Progress Notes revealed that on , Resident #1 was found outside eating leaves. Consequently, the facility provided one on one supervision for Resident #1. Then, the one on one was suspended on because Resident #1 had received an increased

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 010	Continued From page 13 dose of [redacted], and was no longer eating things from outside. However, they had to reinitiate the 24-hour supervision on [redacted]. On [redacted] at 7:30 AM, Resident #1 was observed in the family room with his night PDA. The PDA said that he started working with Resident #1 since last Tuesday or [redacted]. He said that he only works two days Tuesday and Wednesday. He reported that once Resident #1 is awake, he opens all the doors and eats whatever he can find. He chews on everything. He cannot eat at the table with any of the other residents, he will eat their food. When he walks in the hallway, whoever he sees he touches, but he is not aggressive. "He simply has a behavior", he added. He continued and stated that on the night of [redacted] Resident #1 went to sleep at 8:00 PM, he was not able to go anywhere. The PDA said that Resident #1 walked at night in the room because he does not let him go out. He requires constant supervision. However, when he is out in the hallway, he tries to open the other residents' doors and he requires constant redirection. During an interview with the DON on [redacted] at 9:00 AM, he reported that the resident is fine. They sent him to the hospital for a [redacted] evaluation and that he has no problem to be at this facility. He said that he touches everything, he enters resident's rooms but, he means no harm. He also mentioned that most residents with [redacted]. He said that Resident #1 has [redacted] behavior and puts everything in his [redacted]. He indicated that the Resident Physician's Assistant (PA) came to the facility after Resident #1's hospitalization and informed them that Resident #1 was deemed appropriate to reside at the facility. He said "what they are doing to the resident is wrong."	A 010		

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A 010	Continued From page 14 At 9:26 AM, on , an interview conducted with the Resident's sister revealed that Resident #1 has been living at the facility since the end of . . He is a veteran who became ill after his deployment. She confirmed that indeed Resident #1 touches everything and puts everything in his . She said that she warned the facility regarding his care needs. She indicated that they have been trying to get 24-hour supervision for him. However, it took time to transfer his long term care insurance from Miami to Palm Beach. They recently were able to have the insurance transferred to Palm Beach County and that she was told that they would provide 24-hr supervision for him. She said that she had informed the Administration when Resident #1 moved into the facility to lock the bathroom door and closet door; if not, he would go in and put everything in his . She said that he even put his diaper in his . . , he is severely , . But, he is not aggressive. He does not know what he is doing. On at 10:00 AM, in a phone interview conducted with the Resident's Primary Care Physician, he reported that when the resident was first admitted to the facility, he was under the impression that he met the , , that most patients suffers from. However, when he was notified of his behavior after his first week at the facility, he requested that Resident #1 be sent to the hospital for further evaluation. The physician reported that he later noticed that the resident would not be appropriate to remain at the facility unless continuous supervision was provided. He purported that he would not like to see Resident #1's behaviors deprive any resident from their need for privacy and safety.	A 010		

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A 010	Continued From page 15 During an interview with Employee H on [redacted] at 2:00 PM, she said occasionally she worked with Resident #1 at night and he is a handful. She indicated that the resident requires constant supervision and that if left alone, he would enter the other resident's room; especially Resident #2's room which he seems to be fixated on. She indicated that Resident #1 puts everything into his [redacted]. She reflected that she was once very afraid when she had to chase Resident #1 outside in the dark, although the community is gated. She said that she had to leave the other residents inside alone to go outside to try to get Resident #1 so that he would not hurt himself or [redacted]. Review of Resident #1's Health's Assessment revealed the following diagnoses: [redacted], and [redacted] Type 2. He also has [redacted]. He answers to physical stimuli, grabs objects and tries to put items in his [redacted] when hungry. He ambulates and transfers independently, requires supervision for eating and toileting, and requires assistance for bathing, [redacted], and self-care. The record showed that the resident's need can be met in a facility which is not a medical, nursing and [redacted] facility. However, it further noted that the resident's whereabouts, and wellbeing must be observed daily. In addition, he requires medication administration. During an interview with the Administrator on [redacted] at 12:00 PM, the findings were presented to her and she offered no further information but, she agreed that Resident #1 requires 24-hour supervision. She expressed the sentiment that the required services will be provided for Resident #1.	A 010		

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A 010	Continued From page 16 Class III	A 010		
A 052 SS=D	429.256( ); 58A-5.0185 (3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident ' s or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform - level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an	A 052		

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A 052	Continued From page 17 but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not include: (a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) , , or preparations. (g) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. 58A-5.0185 (3)	A 052		

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A 052	Continued From page 18 ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of rule 58A-5.0191, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving	A 052		

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A 052	Continued From page 19 the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and record review, it was determined that the facility's Nurse failed to assist 1 of 3 sampled residents (Resident #2) observed during the medication pass with his/her medications. The findings included: On at 8:00 AM during medication review, it was observed that one of the facility's licensed practical nurse (LPN) was in the	A 052		

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A 052	Continued From page 20	A 052		

med-room when Resident #2 Private Duty Aide (PDA) arrived and requested the resident's medications. The Nurse retrieved the prescribed medication packages, she pushed the pills into a plastic cup and handed them to the PDA who went to Resident #2's room with the pills. This writer immediately followed the PDA to the room.

After entering the room, the PDA was observed taking a small spoon and fed the pills to Resident #2, then she handed Resident #2 a cup of water. Resident #2 swallowed the pills with the water.

Review of Resident #2's health assessment (AHCA Form 1823) dated [redacted] provided no direction regarding the assistance level required by Resident #2 for administration of medications. However, in section I of the form, it was noted that Resident #2 suffered from [redacted], [redacted]'s [redacted] and [redacted]. A second AHCA Form 1823 located revealed it was completed on [redacted], it indicated that Resident #2 self-directed medication administration.

During a follow-up interview with the LPN on [redacted] at 8:11 AM, she reported that she has been working at this facility for about a month. She said that Resident #2's PDA usually comes to the med room to get the resident's medication. She said that if she does not see the Aide by 8:15 AM, she goes to the room to deliver the medication herself. She said that she gave the Aide the medications and that is what she was told to do. However, she later admitted that as a LPN, she should not have done that.

During an interview with the Administrator on [redacted] at 12:00 PM, she expressed her displeasure that this situation occurred indicating

Agency for Health Care Administration

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A 052	Continued From page 21 that the staff had recently completed med/pass training. Class III	A 052		
A 054 SS=D	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.	A 054		

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A 054	Continued From page 22 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that Medication observation record (MOR) was documented according to medication administration guidelines and immediately after assisting residents (Resident #1 & Resident #2) with self-administration of medications or medication administration. The findings included: a) On [redacted] at 8:00 AM during medication review, it was observed that one of the facility's licensed practical nurse (LPN) was in the med-room when Resident #2 Private Duty Aide (PDA) arrived and requested the resident's medications. The Nurse retrieved the prescribed medication packages, she pushed the pills into a plastic cup and handed them to the PDA who went to Resident #2's room with the pills. The PDA returned to Resident #2's room and administered the medications to the resident. The facility's LPN was not present. When this writer returned to the med room after watching the PDA administering the medications to Resident #2, it was observed that the nurse had signed the MOR as though she witnessed Resident #2 take the medications. The medications she signed for were: [redacted] 10 mg 1tablet every morning; [redacted] 0.01 mg 2 tablets every day; [redacted] 75 mcg 1 tablet every morning; [redacted] 100 mg in the morning; [redacted] D3 5000 mg three times a day ( ) and [redacted] 200 mg ½ tablet [redacted]. b) Review of Resident #1's MOR revealed that on [redacted], there were missing signatures on	A 054		

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A 054	Continued From page 23 . . . . . The MOR indicated that the following medications were prescribed: , 10 mg 1 tab by . . . . daily; . . . . . , 10 mg 1 tab by daily; , 0.5 mg, 1 tab by . . . once daily; . . 2000 units 1 tablet by daily. During a follow-up interview with the Nurse on . . . . . at about 8:15 AM, she agreed that she was wrong for signing the MOR without witnessing Resident #2 take her medications. She also reported that she was the one that worked on that day Resident #1's MOR was not signed but she is not sure why she did not sign for all the medications. But, she is convinced that she gave Resident #1 all his medications. During the exit interview with the Administrator on . . . . . at 12:00 PM, the findings were discussed and shared and she agreed. Class III	A 054		
A 079 SS=D	58A-5.019(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 . . 212 16- 25 253 26-35 294 36-45 335 46-55 375 56- 65 416 66-75 457	A 079		

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A 079	Continued From page 24 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 58A-5.024(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 58A-5.0191(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours	A 079		

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A 079	Continued From page 25 when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.	A 079		

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A 079	Continued From page 26 (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of	A 079		

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A 079	Continued From page 27 meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 58A-5.029, 58A-5.030 or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to assess the staffing ratios resulting in insufficient staffing to meet the needs of the residents residing at the facility, for 82 out of 82 residents (Resident #1-#82). The findings included: a) On at 9:00 AM, during a tour in the courtyard of Cottage #1 and #2, it was observed and noted that Resident #1 was outside, while an Private Aide was trying to encourage him to go inside the facility. Resident #1 sat on the bench and did not want to go inside. On at 10:14 AM, during a meeting with the Executive Director, she reported that she has been receiving multiple complaints from Resident #2's family member recently regarding Resident #1's behavior and into Resident #2's room; exhibiting touching and grabbing behavior (including residents). She further stated that the Family member has made a remark to the nurse indicating that she was okay with the other residents in her mother's room, but this resident was different, that he is {skin tone identified}. The Nurse present during the interview reported that the family member's complaints were racially motivated.	A 079		

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During an interview with Employee (I) on at 11:59 AM, she reported that she assists with activities. She said that Resident #1 around and likes staying outside. He also exhibits PICA behaviors. Resident#1 requires redirection from time to time. She has been told that Resident #1 into other residents' rooms, but she has not witnessed such behavior. She said that Resident #1 is not aggressive and to her "he is a sweetheart". She said the resident is helpful and tries to open up the doors for other residents but that act and other behaviors might be misinterpreted due to a lack of communication. She indicated that Resident #1 is non-verbal, he "mumbles" his words.

During an interview with one of Resident #1's PDA on at 12:19 PM, she reported that she works three days a week from 11 AM to 11 PM. She said that she is hired by an agency. She said that the Resident #1 is very nice. When she arrived to work today, Resident #1 was happy when he saw her and was so happy that he gave her a hug; because, she cared for him once before. She reported that Resident #1 puts everything in his . Consequently, they have to keep the bathroom's door closed so that Resident #1 does not drink water from the sink or eat things from the bathroom. They also keep his closet doors closed. The resident was observed wearing a jumper suit. The PDA explained and said that it was because Resident #1 would remove his clothes, if they put shirt and pants on him, to put them in his . She said that he acts like a child. Resident #1 was observed in bed laying down.

On at 12:39 PM, during a confidential family interview, the following was revealed. They

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observed Resident #1 walking into their mother's room and trying to go into the mother's bed. The family members reported that Resident #1 was acting like a child, but he was strong. One of the members said when she tried to redirect Resident #1, she quickly realized that the task was going to be a challenge for her. So, she called for help and the facility staff came right away and they were able to redirect Resident #1 without any problem. She said that the staff is very caring. However, she was not sure whether Resident #1 was appropriate for this unit. It was also revealed that Resident #1 placed his . . . . on his . . . . . a couple of times but, he was able to redirect him. He said "man can tolerate that behavior but the ladies not so much". They indicated that Resident #1 had no one supervising him at that time.

On . . . . . at 10:56 AM, Resident # 1's PDA reported that on , she worked one week and half week with Resident #1. She indicated that there was another man who also worked with Resident #1 during the night of . . . . . The PDA reported that Resident #1 requires total care for all ADLs, and he also requires medication administration. Resident #1 cannot feed himself, he would dirty all his clothes and . . . , she said. In order words, he requires higher level of care. The PDA reported that the night worker told her that Resident #1 did not sleep at all, the night before.

On . . . . . at 11:00 AM Resident #2's PDA reported that she has been working with Resident #2 for a long time. She stated that she is a licensed practical nurse (LPN). She said that on multiple occasions Resident #1 was left unsupervised and he eventually went into other residents' rooms. She said that they used to place the meals on the counter before serving them to

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the residents, and Resident #1 would grab them and eat them and create a total mess. She said, that is why they now place the meals on a table cloth on the counter as observed, so that they can have time to pull all of them away at the same time in case Resident #1 would be near the counter. She explained when the staff stands inside the kitchen preparing the meals, they would not have time to refrain Resident #1 from reaching out for the foods on the counter. She also reported that she can understand Resident #1 [redacted] and grabbing things, but the problem is that they are not supervising him and think that his behavior is acceptable. She said that she is used to residents and patients grabbing body parts all the time, but the behavior is not acceptable. She indicated that Resident #1 does not know what he is doing. He is not aggressive, but he invades others' privacy.

On [redacted] at 1:06 PM, Resident #2's daughter's confirmed numerous problems regarding Resident #1's behavior of [redacted], entering various resident's rooms (including Resident #2). It was also revealed that the Administrator was informed on numerous occasions of the concerns.

On [redacted] at 2:32 PM, during an interview with Resident #2 and her husband, Resident #2 reported in a shallow sounded voice that there are serious concerns of lack of monitoring of Resident #1. Resident #2 said that she was definitely afraid of Resident #1. She said that Resident #1 came to the room and tried to get into her bed. She does not appreciate that. The husband however indicated that he had not witnessed the resident being aggressive. He said that he understands that it is not Resident #1's fault, but it is wrong that the Administration has

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A 079	Continued From page 31 not provided the level of supervision that Resident #1 requires. Review of the Nurses' Progress Notes revealed that on , Resident #1 was found outside eating leaves. Consequently, the facility provided one on one supervision for Resident #1. Then, the one on one was suspended on because Resident #1 had received an increased dose of , and was no longer eating things from outside. However, they had to reinitiate the 24-hour supervision on . On at 7:30 AM, Resident #1 was observed in the family room with his night PDA. The PDA said that he started working with Resident #1 since last Tuesday or . He said that he only works two days Tuesday and Wednesday. He reported that once Resident #1 is awake, he opens all the doors and eats whatever he can find. He chews on everything. He cannot eat at the table with any of the other residents, he will eat their food. When he walks in the hallway, whoever he sees he touches, but he is not aggressive. "He simply has a behavior", he added. He continued and stated that on the night of Resident #1 went to sleep at 8:00 PM, he was not able to go anywhere. The PDA said that Resident #1 walked at night in the room because he does not let him go out. He requires constant supervision. However, when he is out in the hallway, he tries to open the other residents' doors and he requires constant redirection. During an interview with the DON on at 9:00 AM, he reported that the resident is fine. They sent him to the hospital for a , evaluation and that he has no problem to be at this facility. He said that he touches everything, he enters resident's rooms but, he means no	A 079		

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harm. He also mentioned that most residents with . He said that Resident #1 has behavior and puts everything in his . He indicated that the Resident Physician's Assistant (PA) came to the facility after Resident #1's hospitalization and informed them that Resident #1 was deemed appropriate to reside at the facility. He said "what they are doing to the resident is wrong."

At 9:26 AM, on , an interview conducted with the Resident's sister revealed that Resident #1 has been living at the facility since the end of . He is a veteran who became ill after his deployment. She confirmed that indeed Resident #1 touches everything and puts everything in his . She said that she warned the facility regarding his care needs. She indicated that they have been trying to get 24-hour supervision for him. However, it took time to transfer his long term care insurance from Miami to Palm Beach. They recently were able to have the insurance transferred to Palm Beach County and that she was told that they would provide 24-hr supervision for him. She said that she had informed the Administration when Resident #1 moved into the facility to lock the bathroom door and closet door; if not, he would go in and put everything in his . She said that he even put his diaper in his . he is severely . But, he is not aggressive. He does not know what he is doing.

On at 10:00 AM, in a phone interview conducted with the Resident's Primary Care Physician, he reported that when the resident was first admitted to the facility, he was under the impression that he met the , that most patients suffers from. However, when he was notified of his behavior

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after his first week at the facility, he requested that Resident #1 be sent to the hospital for further evaluation. The physician reported that he later noticed that the resident would not be appropriate to remain at the facility unless continuous supervision was provided. He purported that he would not like to see Resident #1's behaviors deprive any resident from their need for privacy and safety.

During an interview with Employee H on at 2:00 PM, she said occasionally she worked with Resident #1 at night and he is a handful. She indicated that the resident requires constant supervision and that if left alone, he would enter the other resident's room; especially Resident #2's room which he seems to be fixated on. She indicated that Resident #1 puts everything into his . . . She reflected that she was once very afraid when she had to chase Resident #1 outside in the dark, although the community is gated. She said that she had to leave the other residents inside alone to go outside to try to get Resident #1 so that he would not hurt himself or . .

Review of Resident #1's Health's Assessment revealed the following diagnoses: , , and . Type 2. He also has , . He answers to physical stimuli, grabs objects and tries to put items in his when hungry. He ambulates and transfers independently, requires supervision for eating and toileting, and requires assistance for bathing, , and self-care. The record showed that the resident's need can be met in a facility which is not a medical, nursing and facility. However, it further noted that the resident's whereabouts, and wellbeing must be observed daily. In addition, he requires

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A 079	Continued From page 34 medication administration. During an interview with the Administrator on at 12:00 PM, the findings were presented to her and she offered no further information but, she agreed that Resident #1 requires 24-hour supervision. b) During an observation conducted at 12:50 PM in Cottage #1, on , Resident #3 was observed going into the laundry room and closed the door behind her. At this time, Employees C was observed assisting another resident with dining, and Employee D was doing the dishes. Neither of the two employees in the Cottage witnessed Resident #3 going inside the laundry room. They became aware only after this writer inquired about the whereabouts of Resident #3. Then, they frantically opened up the laundry room to usher Resident #3 out. The laundry room contained multiple cabinets,inside one of the cabinet were the following items: Lysol Cleaner, Multi Surface Cleaner and , a gallon of Multi Surface Cleaner and ¾ full. The dryer was running and the water heater room was unlocked. None of the cabinets were locked. In addition, there were three capped razors observed in a bin that also contained shaving cream. Review of Resident #3's health assessment section I indicated that she has a diagnosis of , and was an elopement risk. In addition, in section A, there was indication for facility Staff to monitor Resident #3's wellbeing and whereabouts daily. A tour conducted in all the other Cottages #2, #3, #4, #5, #6 and #7 immediately after observing Resident #3 in the laundry room in Cottage #1	A 079		

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revealed that three other laundry rooms were also unlocked.

c) On at 8:30 AM, after arriving at the facility and entering Cottage #1, 6 residents were observed in the dining room waiting for breakfast, they sat in their wheelchairs. It was noted that there were pancakes on the stove unattended and uncovered.
At 8:46 AM, Employee I came out from one the rooms and said that they were preparing residents for breakfast. At 8:50 AM, Employee I started to put on clothing protector on the residents and placed water in front of them. off. At 9:01 AM, the first group of residents were served.

On , Resident #1 was observed in his room with the private duty aide (PDA). He was observed chewing on his comforter. Then, the aide took him out to walk. Review of Resident #1's health assessment revealed that Resident #1 grabs things and tries to put them into his , when he is hungry. Resident #1 was noticeably in need of food by making several attempts to go next to the food prep area. He was refrained by the PDA. He tried to grab the PDA's to chew on it. At 9:06 AM, Employee I gave the food to the PDA for Resident #1. He was so eager to eat that he started to chew on the clothing protector at the sight of his meal. Then, the PDA fed him. He ate extremely fast and was asking for more food and was observed to be restless. Resident #1 ate cereal, pancakes and omelets, juice, banana and water. Immediately after, he was observed to be quiet, he extended his . . . on the couch and was noted to be quiet.

During a confidential staff interview conducted on at about 8:55 AM, it was reported that

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A 079	Continued From page 36 they gave the food too late to the residents. At lunch time on [redacted] at 11:30 AM, Staff D placed the residents at the table. At 12:00 PM, there was only 1 staff member assisting the residents. Employee D went to each resident and placed clothing protectors on all of them. At 12:01 PM, Employee (I) arrived to assist with dining. She washed her [redacted]. She sat next to two residents (Resident #4 & #5) and was observed feeding both residents at the same time. At 1:00 PM, Resident #6 was fed by Employee I. In an interview conducted with Employee I, thereafter, she reported that there is not enough help during dining, so they have to feed Resident # 6 after they finish feeding all the other residents. On [redacted] at 7:30 AM, five residents were observed in the dining room, sitting down at the table waiting for breakfast. There was no food being prepared in the kitchen, and there was no one nearby. This writer observed the residents half-awake. They stayed there until 9:00 AM without any one talking to them, any stimulation and any food or drinks. They sat there waiting for their meals. Meals were finally served at 9:10 AM. Class III	A 079		