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
	AL11943023	A. BUILDING: _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

(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 2019005007, 2019007298, and 2019005496, was conducted on through at Lighthouse Inn North. The facility had deficiencies at the time of the survey.	A 000		
A 007 SS=D	429.26(11) FS; 58A-5.0181(1) FAC Admissions - Criteria 429.26 (11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part of chapter 400, shall be retained in a facility licensed under this part. 58A-5.0181 (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least . 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has , ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of	A 007		

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A 007	Continued From page 1 medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility exploys a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a physician, or mental health practitioner licensed under chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden. 10. Not have any [illegible] or 4, [illegible] A resident requiring care of a [illegible] may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care provider; b. The condition is documented in the resident's	A 007		

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A 007	Continued From page 2 record and admission and discharge logs; and, c. 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. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with , c. Monitoring of gases, d. Management of post-surgical drainage tubes and vacuum devices; e. The administration of products in the facility; or f. Treatment of surgical or , unless the surgical or and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. , and , , performed in the facility; b. , , performed in the facility. 13. Not require 24-hour nursing supervision. 14. Not require skilled rehabilitative services as described in rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and	A 007		

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A 007	Continued From page 3 preferences of the individual; b. The medical examination report required by section 429.26, F.S., and subsection (2) of this rule, if available; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable [illegible] or assistance with routine [illegible] care of [illegible] site [illegible] placement, may be admitted to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from [illegible] with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) An individual enrolled in and receiving hospice services may be admitted to an assisted living facility as long as the individual otherwise meets	A 007		

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A 007	Continued From page 4 resident admission criteria. (e) Resident admission 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 interview and record review, the facility failed to admit residents who meet the minimum admission criteria requirement, for 1 of 3 sampled resident records reviewed (Specifically, Resident # 1). The findings included: On at 01:00 PM, an interview was conducted with the Administrator. She stated Resident # 1 was brought into the facility by the previous facility for a tour. She says she does not know where he came from previously. She stated that the resident had a . She stated she did not want to accept him. She says she sent him to the hospital. She says the hospital sent him . She says she and a nurse from the Home Health Agency that checked him out; and they noticed that he shouldn't have been placed in the facility. She says he is currently a resident. She stated she did not know what to do with the resident, because he didn't have anywhere else to go. She says she believes he came in . She confirmed that she does not currently have a nurse on duty or under contract to perform the health assessments. She stated the was healed when the resident returned to their facility. She confirmed that the resident was never under Hospice Care. A review of the Florida Health Assessment form (AHCA form 1823) from the current facility was	A 007		

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A 007	Continued From page 5 conducted. The form was dated . . . . . He suffered from , , and , . Physical or sensory diagnosis: Can't walk. , or behavioral status: Stable. Nursing/treatment/ , , service requirements: , , , and the Special precautions: precaution. He is independent with his Activities of Daily Living. He ambulates with a wheelchair. A review of the , , , , , , notes dated was conducted. The Psychiatrist deems Resident # 1, Alert and Oriented x 3. His diagnosis is , . On at 01:45 PM, an interview was conducted with Resident # 1. He says he came from another facility. He says the current facility did not check him when he moved in for any sores. He says he did have a , , . . . when he came and was admitted there. He says he left the facility and went over to the hospital. He says he told the staff that he was in a great deal of , . He says he did see the podiatrist on a regular basis when he returned from the hospital after a one month stay. He stated the . . . was better after he returned to the facility. A review of the Home Health Script was conducted. The script is dated . . . . . Cleanse. Apply lightly, bandage daily. A request for additional home health notes was made. There was no further documentation provided regarding . . . . care from a Third Party Provider. The location, dimensions and care of the . . . . was not determined based on documentation provided. A review of the resident progress notes reveals	A 007		

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A 007	Continued From page 6 the following. a) - A new resident moved in today. He has two pressure areas, on right . He was sent out to the hospital. b) - Today, Resident # 1 had a doctor's , for his . The right one and he'll be later. c) - Resident # 1, said that he needed to go to the hospital because he had no feeling in his right . Non-emergency was contacted and his mother. And send to the hospital. d) - Resident # 1 came from the hospital and he had a in his and new prescriptions. But better. e) - Today, Resident # 1 had a doctor , and will be later. f) - Resident # 1 is ok. He went to see his doctor today but other than that, no complaints. On at 03:00 PM, an interview was conducted with the Administrator. She acknowledged the findings. Class III	A 007		
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	A 008		

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A 008	Continued From page 7 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. 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	A 008		

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A 008	Continued From page 8 individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] 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 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 [illegible] require such assistance. 58A-5.0181 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a [illegible]-to-[illegible] 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	A 008		

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A 008	Continued From page 9 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 [illegible] 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 [illegible] or any other communicable [illegible], 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, 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, [illegible], 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	A 008		

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A 008	Continued From page 10 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 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	A 008		

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A 008	Continued From page 11 . . . . . 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 interview and record review, the facility failed to ensure the accuracy and timeliness of the Florida Health Assessment form, (form 1823). The 1823 form did not include the correct diagnosis, nor was the form completed within 30 days of admission for 1 of 3 sampled resident records reviewed. (Specifically, Resident # 1). The findings included: On . . . . . at 01:00 PM, an interview was conducted with the Administrator. She stated Resident # 1 was brought into the facility by the previous facility for a tour. She says she does not know where he came from previously. She stated that the resident had a . . . . . On . . . . . a review of the Florida Health Assessment form (AHCA form 1823) was conducted. The following information was recorded for Resident # 1. The 1823 form was	A 008		

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A 008	Continued From page 12 dated . . . . He suffered from . . . . . , and . . . . . Physical or sensory diagnosis: Can't walk. . . . . or behavioral status: Stable. Nursing/treatment/ . . . . service requirements: . . . . . , and the Special precautions: . . . precaution. He is independent with his Activities of Daily Living. He ambulates with a wheelchair. On . . . . . at 01:45 PM, an interview was conducted with Resident # 1. He says he came from another facility. He says the current facility did not check him when he moved in for any sores. He says he did have a . . . . . when he came and was admitted there. He says he left the facility and went over to the hospital. He says he told the staff that he was in a great deal of . . . . He says he did see the podiatrist on a regular basis when he returned from the hospital after a one month stay. He stated the . . . . was better after he returned to the facility. A review of the resident progress notes reveals the following. On . . . . . , a new resident moved in today. He has two pressure areas, ... on right . . . . He was sent out to the hospital. A review of the hospital admission sheet shows that Resident # 1 was admitted into the hospital on . . . . . . Although, the resident was admitted to the facility on . . . . . ; the AHCA form 1823 was not completed until . . . . . . Neither does the form accurately reflect his care needs (including nursing needs) and diagnosis. On . . . . . at 03:00 PM, an interview was	A 008		

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A 008	Continued From page 13 conducted with the Administrator. She acknowledged the findings. Class III	A 008		
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	A 052		

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	AL11943023	A. BUILDING: _____ B. WING _____	07/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE INN NORTH	3208 N.E. 11 STREET POMPANO BEACH, FL 33062

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A 052	Continued From page 14 stockings. (j) Assisting with applying and removing an 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.	A 052		

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A 052	Continued From page 15 58A-5.0185 (3) 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,	A 052		

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A 052	Continued From page 16 2. The medication container may be given to the resident, a friend, or family member upon leaving 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, interview and record review, the facility failed to follow the proper protocol and procedure for unlicensed staff assisting residents with self-administration of medication. Unlicensed staff failed to dispense medication in the presence of the resident for 5 of 5 medication assistance observations. (Specifically, Residents # 2, # 4, # 9 , # 10, and # 11).	A 052		

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A 052	Continued From page 17 The findings included: On at 12:30 PM, an observation of the assistance with self administration of medication was conducted. Staff A was observed popping the medications from their original bubble packets at the medication cart. She compared the medication again to the Medication Observation Record. She then replaced the medication packets into the drawer of the medication cart. She took the medications to the dining room tables for the following residents in the pill cups: 1. Resident # 02, , 10 mg 2. Resident # 09, Midodrine 10 mg 3. Resident # 10, , 500 mg, Lamactol 28 mg, and , 300 mg 4. Resident # 04, , 10 mg, 5. Resident # 11, , 10/325 mg, , 10 mg On at 03:00 PM, an interview was conducted with the Administrator. She acknowledged the findings. Class III	A 052		