

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967983	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/22/2019
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GLADE GARDEN

**5860 91ST AVENUE
PINELLAS PARK, FL 33782**

(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 A revisit to a biennial survey was conducted at Glade Garden on Deficiencies were found not to be corrected at the time of the survey.	{A 000}		
{A 032} SS=D	58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(f) Resident Care - Elopement Standards 58A-5.0182 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 58A-5.0181(2) (a), F.A.C., this requirement is satisfied. 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 this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 58A-5.0191(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary.	{A 032}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{A 032}	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1){a}3. and 429.41(1){l}, F.S. 429.41(1){a}3 & 3(l),FS 3. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the	{A 032}			

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{A 032}	Continued From page 2 drills are conducted in a manner consistent with the facility's resident elopement policies and procedures. (I) The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to demonstrate they had been conducting elopement drills. Findings included: In an interview at 10:30am on _____, with Staff B, who was the acting manager of the facility and stated being present on site "all of the time", Staff B questioned AHCA about what an elopement drill was or the reasoning behind it. Staff B was not able to provide any documentation they the facility held any elopement drills. In an interview with Staff A, the Administrator via telephone at 12:30pm on _____, she acknowledged that the facility was not keeping a log of elopement drills. Class III (A 083) SS=D 58A-5.0191(5) FAC Training - First Aid and (5) FIRST AID AND _____ (_____). A staff member who has completed courses in First Aid and _____ and holds a currently valid card documenting completion of such courses must be in the facility	{A 032}		
		{A 083}		

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{A 083}	Continued From page 3 at all times. (a) Documentation that the staff member possess current . . . certification that requires the student to demonstrate, in person, that he or she is able to perform . . . and which is issued by an instructor or training provider that is approved to provide . . . training by the American Red Cross, the American . . . Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, 2 of 2 staff sampled (Staff A and Staff B), did not have current First Aid training or () certification approved by the American Red Cross, American Association, the National Training Safety Council or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education. Findings included: A review of Staff A's record was conducted on The certificate in Staff A's record revealed a certificate for a . . . course that was not approved by the American Red Cross, American . . . Association, the National Training Safety Council or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education. No other	{A 083}			

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{A 083}	Continued From page 4 current . . . training was found in Staff A's record. A review of Staff B's record was conducted on Staff B's record revealed a certificate for First Aid training that was not approved by the American Red Cross, American . . . Association, the National Training Safety Council or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education. At 11:30am on , in an interview with Staff B, the acting manager of the facility who stated he was in the facility "all of the time" and usually "by himself", Staff B stated that the . . . and First Aid training that Staff A and Staff B received was done online. In an interview with Staff A, via telephone, at 12:30pm on , she stated she thought it was okay to do a . . . course on line and was not aware of AHCA's requirement for obtaining approved training by the American Red Cross, American . . . Association, the National Training Safety Council or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education. Class III	{A 083}			
{A 093} SS=D	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and	{A 093}			

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{A 093}	Continued From page 5 available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003 , and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf . Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.	{A 093}		

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{A 093}	Continued From page 6 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the	{A 093}		

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{A 093}	Continued From page 7 purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility had not been documenting when it substituted items from its menu over the last six months. Findings included: A revisit survey was conducted on At 12:00pm on, Staff B, the acting manager of the facility, was asked to provide the facility's substitution log of food items substituted from the facility's menu prepared for the facility by the dietician. Staff B did not have a substitution log and asked AHCA what it was for. Staff B stated that he is in charge of preparing meals for the residents and that sometimes he buys pizza or Chinese food for everyone. He stated the residents request the changes to the menu, but that the facility does not write it down in a	{A 093}			

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{A 093}	Continued From page 8 substitution log. Staff B stated that he already paid the dietician for the menus and therefore did not think he should have to do extra work if the residents request a substitute. Class III	{A 093}		
{AL243} SS=D	429.075(1) FS; 58A-5.0191(9) FAC LMH - Training 429.075 (1) To obtain a limited mental health license, a facility must hold a standard license as an assisted living facility, must not have any current uncorrected deficiencies or violations, and must ensure that, within 6 months after receiving a limited mental health license, the facility administrator and the staff of the facility who are in direct contact with mental health residents must complete training of no less than 6 hours related to their duties. Such designation may be made at the time of initial licensure or relicensure or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with this part, part II of chapter 408, and applicable rules. This training will be provided by or approved by the Department of Children and Families. 58A-5.0191 (9) LIMITED MENTAL HEALTH TRAINING. (a) Pursuant to section 429.075, F.S., the administrator, managers and staff, who have direct contact with mental health residents in a licensed limited mental health facility, must receive the following training: 1. A minimum of 6 hours of specialized training in working with individuals with mental health	{AL243}		

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{AL243}	Continued From page 9 diagnoses. a. The training must be provided or approved by the Department of Children and Families and must be taken within 6 months of the facility's receiving a limited mental health license or within 6 months of employment in a limited mental health facility. b. Training received under this subparagraph may count once for 6 of the 12 hours of continuing education required for administrators and managers pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 2. A minimum of 3 hours of continuing education, which may be provided by the ALF administrator, online, or through distance learning, biennially thereafter in subjects dealing with one or more of the following topics: a. Mental health diagnoses; and, b. Mental health treatment such as: (i) Mental health needs, services, behaviors and appropriate interventions; (ii) Resident progress in achieving treatment goals; (iii) How to recognize changes in the resident's status or condition that may affect other services received or may require intervention; and, () Crisis services and the ... procedures. 3. For administrators and managers, the continuing education requirement under this subsection will satisfy 3 of the 12 hours of continuing education required biennially pursuant to section 429.52(5), F.S., and subsection (1) of this rule. 4. Administrators, managers and direct contact staff affected by the continuing education requirement under this subsection shall have up to 6 months after the effective date of this rule to meet the training requirement.	{AL243}		

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{AL243}	Continued From page 10 (b) Administrators, managers and staff do not have to repeat the initial training should they change employers provided they present a copy of their training certificate to the current employer for retention in the facility's personnel files. They must also ensure that copies of the continuing education training certificates, pursuant to subparagraph (a)2. of this subsection, are retained in their personnel files. This Statute or Rule is not met as evidenced by: Based on record review and interview, 3 of 3 staff members sampled (Staff A, Staff B and Staff C), had not obtained the minimum 3 hours of continuing education in subjects related to mental health. Findings included: A record review, in conjunction with a revisit to correct previous deficient practice, was conducted on . Staff A's record revealed a certificate for 2 hours of continuing education training for mental dated on . No further continuing education training on mental health within the past 2 years was found in Staff A's record. Staff B's record revealed a certificate for 2 hours of continuing education training for mental dated on . No further continuing education training on mental health within the past 2 years was found in Staff B's record. Staff C's record revealed no continuing education training on mental health within the past 2 years. Staff C had been working in the facility a number of years and was on the current schedule. In an phone interview with Staff A at 12:30pm on	{AL243}		

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{AL243}	Continued From page 11 she stated that she did not know that the requirement was for 3 hours of continuing training on mental health issues every 2 years. Class III	{AL243}			