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
	AL11911412	A. BUILDING: _____ B. WING _____	09/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVEWELL AT COURTYARD PLAZA	15520 NW 2 AVENUE NORTH MIAMI BEACH, FL 33160

(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
CZ813 SS=D	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090(3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep a signed Attestation of Compliance with Background Screening Requirements form for four out of 22 sampled staff members (Staff E, G, I, and K). Findings included: Review of Staff I's personnel record revealed Staff I was hired on . . . and showed no documentation of a signed Attestation of Compliance with Background Screening Requirements form. Further review of Staff I's personnel records revealed the form was missing page # 4 where Staff I was supposed to have signed. Review of Staff K personnel record revealed Staff K was hired on and showed no evidence of a signed Attestation of Compliance with Background Screening Requirements form. Further review of Staff K's personnel records revealed the form was missing page # 4 where Staff K was supposed to have signed. On . . . . at 2:23 PM, the Assistant Administrator stated that the attestation form was	CZ813		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ813	Continued From page 1 probably misplaced when the papers were filed. At 2:24 PM, she added that she needed to look for them. Review of Staff G's personnel record revealed Staff G was hired on and showed no documentation of a signed Attestation of Compliance with Background Screening Requirements form. Further review of Staff G's personnel records revealed the form was missing page # 4 where Staff G was supposed to have signed. On at 2:27 PM, the Assistant Administrator stated, "No, I don't find it. It is strange because the rest of the information is on record." Review of Staff E's personnel records revealed Staff E was hired on and showed no documentation of a signed Attestation of Compliance with Background Screening Requirements form. Further review of Staff E's personnel records revealed the form was missing page # 4 where Staff E was supposed to have signed. On at 2:29 PM, the Assistant Administrator stated that it was strange because the rest of the information was on record. Class III	CZ813		

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A 000	Initial Comments A complaint investigation (# 2019014679) was conducted at Livewell at Courtyard Plaza on and concluded on . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

AHCA Form 3020-0001

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services appropriate to meet the needs of four out of 33 sampled residents (Resident # 1 - 3 and # 16). Resident # 1 was sent to the hospital for a change in behavior and . Upon arrival, Resident # 1 was found with grapefruit sized , to the left side of the , left shut, from the , and and to the right side of the . Resident # 2 was sent to the hospital with a black after being assaulted by Resident # 3. Resident # 3 had a history of aggressive behavior and there were no interventions in place to prevent recurrence of the incident. Resident # 16 was found to be unsupervised chewing on a facility's plant. Findings Included: 1) A review of the facility's admission and discharge log revealed Resident # 1 was admitted to the facility on and discharged on	A 025		

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A 025	Continued From page 2 On [redacted] at 1:32pm, when asked what the Director of Nursing (DON) knew about Resident # 1, she stated the resident was currently at the hospital. The DON had received a call from Staff Q on Sunday morning ([redacted]) at approximately 3 am. Staff Q had then reported to her that Resident # 1 was not herself. She continued to state that Staff Q described Resident # 1 as 'weak, as if she would [redacted] '. She was told by Staff Q that an aide had alerted her about the changes in Resident # 1's condition and instructed Staff Q to observe Resident # 1 throughout the day. The DON then stated that on the same day at approximately 9:30 am, Staff Q had called her a second time because Resident # 1's condition worsened. Staff Q had told her Resident # 1 was 'more weak, [redacted], and [redacted] '. She also stated that she had instructed Staff Q to call the non-emergency ambulance and that the paramedics had arrived at approximately 1 pm. Staff Q then told her that she had gone inside Resident # 1's room with the paramedics and found the resident lying in bed with blackish/blueish [redacted] and a [redacted]. Staff Q had reported to her that the change in Resident # 1's [redacted] happened within an hour time frame from the time the ambulance was called. A review of Resident # 1's records revealed a preliminary incident report dated [redacted] at 12 pm with Resident # 1's name. The report showed Staff C was involved and reported by Staff Q. The report also revealed that Staff L and the Administrator were notified of the incident. Further review of the report revealed a summary stating 'Resident # 1 walked into the dining Room for breakfast she seemed disoriented and was walking with her [redacted] down and seemed a bit	A 025		

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A 025	Continued From page 3 . I called the Certified Nursing Assistant (CNA) on duty and informed her to keep an on Resident # 1 while I informed the Director of Nursing (DON) of her symptoms. DON suggested I call the nonemergency hot line. Resident had no . The resident only seemed disoriented and and had change in behavior'. A review of hospital records revealed Resident # 1 was transferred on from a local hospital to a unit due to a hematoma (associated with a). A final report stated "On arrival to the emergency department noted the patient has significant left-side , multiple and that appears to be 2 to 3-day old. The onset was unknown. The course/duration of symptoms is unknown". A CT (Computed) Scan (described by the Mayo Clinic as a combination of images taken from different angles around the body which uses computer processing to create cross section images of tissues or bones) revealed the resident had significant and hematoma (solid of clotted within the tissues) on the left side of the extending from the frontal region of the to the (jaw). Further review of hospital records revealed Resident # 1 was diagnosed with displacement of lens, with loss of , and unspecified of bones. According to WebMD, a is a collection of outside of the and usually caused by severe injuries. Whereas, lens is a medical device inside the to replace the 's natural lens when it is removed during surgery. According to the American Society of	A 025		

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A 025	Continued From page 4 , one of the causes for displacement of the lens is to the . Hospital records also revealed a document from the facility labeled 'Notes for Hospital visitation' with Resident # 1's name, a checked section that stated, 'Major change in behavior', and a section for additional notes that stated, 'Major change in behavior and '. An additional review of Resident # 1's records showed she was admitted to the facility on and an observation note dated stating that Resident # 1 was sent to the hospital for evaluation for and . There was no documentation that the resident had extreme and of the fact. There was also no documentation that the resident had or obtained any injury. Further review of Resident # 1's health assessment revealed she was diagnosed with Hyponatremia and ( ); however, hospital records revealed Resident # 1 was diagnosed with Hyponatremia, , ( ), and type . On at 2:48pm, Staff Q stated, "I noticed she was not herself, , breathing fast and not walking right". She also stated that she had contacted the DON to advise her that Resident # 1 was not feeling well and was told to check her . Staff Q then called the DON again to report the reading and the DON had told her "I will not send Resident # 1 to the hospital, just watch her". Furthermore, Staff Q stated "I saw Resident # 1 walk past me, she seemed a bit . Her posture was not the same. She walked hunched over, but this time	A 025		

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A 025	Continued From page 5	A 025		

the hunch looked worse. The med tech and kitchen staff told me Resident # 1's diaper was slipping off. I tried to take her to the room to change her diaper. Resident # 1 did not want to go to her room and did not want to leave the dining room, she wanted to eat. Resident # 1 had no [illegible] on her [illegible]". Staff Q then added "When the ambulance came, I went to the room with paramedics and saw [illegible] on Resident # 1's [illegible]. I checked the surroundings, and nothing seemed like it was moved. I told the paramedics I thought it was an [illegible] reaction. When she came to the dining room, her [illegible] did not look like that".

On [illegible] at 4:09pm, Staff I stated that she saw Resident # 1 the day before the resident was sent to the hospital. Staff I stated that before her shift on [illegible] at 11pm, the staff member she was relieving, who had worked the [illegible] pm shift, had told her to keep an [illegible] on Resident # 1 because she was not feeling well. Staff I further stated that she was conducting rounds and found Resident # 1 sitting in the shower chair between 1 - 3 am and said that it was unusual for Resident # 1 to take a shower so late at night. Staff I also stated, "I took her out of the shower to bed and noticed she was breathing fast". Staff I then stated that she called the DON twice. Staff I said "I told the nurse to send her to the hospital and the nurse did not want to send her out right away and said to keep a close [illegible] on her. I took her [illegible], which was [illegible] and the DON told me that it was normal and keep an [illegible] on her to observe her a little more before sending her to the hospital".

A review of Staff Q's personnel files revealed a document titled 'Procedures for All Nursing Dept Staff'. The document stated, 'When an incident

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A 025	Continued From page 6 occurs that requires paramedics or transport, one staff member must remain with the resident until they are transported out of the facility'. Review of the facility's surveillance footage revealed Resident # 1 with [illegible], and further showed Staff C had entered and left the room multiple times, leaving Resident # 1 unsupervised. On [illegible] at 10am, when asked if Resident # 1's [illegible] looked [illegible], the Administrator stated, "That's Resident # 1. I was told that she had a little [illegible], and a little discoloration". The Administrator also stated that she got a call from the hospital and was told that she was being transported to the [illegible] unit because of a [illegible], "I'm not a nurse, but cross trained as one and a [illegible] can cause discoloration and [illegible] to the [illegible]". The Administrator also stated no investigation was conducted to find out what had happened to Resident # 1. On [illegible] at 10:50am, Resident # 5 stated "I noticed Resident # 1 was not herself for a couple of days. She [illegible] a day before she went to the hospital. She didn't have proper coordination and I saw her [illegible]". Resident # 5 also stated that approximately 2 days before she went to the hospital, Resident # 1 had [illegible] again while walking backwards and Resident # 5 had called for an employee for help. Furthermore, Resident # 5 described Resident # 1's condition worsened and had to help Resident # 1 get up from the second time she had [illegible]. He also stated that he believed Staff H noticed Resident # 1's [illegible] was [illegible]. On [illegible] at 1:24pm, Staff C confirmed she worked on [illegible] and had taken care of Resident # 1. Staff C stated that she heard	A 025		

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A 025	Continued From page 7 Resident # 1 screamed out her name and ran to the room. Staff C had then left the room and waved down Staff A to come help her. Staff C was not able to explain what kind of assistance Resident # 1 was screaming for and did not understand why Resident # 1 screamed out her name. Staff C stated, "I did not go over to her"; however, she later stated that Resident # 1 was lying in bed when she arrived to the room. When asked if she noticed if Resident # 1 had any . . . . , or . . . . , to her . . . , she stated "no, she did not have anything on her ". On at 2:30pm, Staff A stated that Staff C had contacted her over the radio on . . . . to go to Resident # 1's room to see Resident # 1's because it was and . . . . She also stated that a resident had told her that Resident # 1 had . . . . In addition, Staff A stated that she had told Resident # 5 that Resident # 1's . . . weren't from the same day. On . . . . . at 10:55am, Staff H stated that she saw Resident # 1 the night before she went to the hospital. She was able to speak to the resident and stated Resident # 1 looked "perfect" and was laying down in bed. She also stated that she heard Resident # 1 had and that's why she was sent to the hospital. 2) On . . . . . at 11:35am, an interview with Resident # 2 revealed that he was recently in the hospital because he was punched in the . . . by a resident. Resident # 2 stated that he does not recall who the resident was and does not remember much of what happened. A review of Resident # 2's observation note dated	A 025		

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A 025	Continued From page 8 showed that Resident # 2 was sent to the hospital after an altercation with another resident and an evaluation was requested. Additionally, there was a note for hospital visitation which stated that Resident # 2 had on the left side of his and lower . The note stated "Resident has complained of on the left side of the and after altercation with another resident striking and shoving him. Please evaluate". A second observation note dated stated that Resident # 2 returned to the facility with no change or orders provided, stable no concerns at this time. Further review revealed a health assessment which stated Resident # 2 was diagnosed with Early Onset , , and Type II . A review of hospital records revealed that Resident # 2 arrived there with a black . A review of the facility's records revealed an internal incident report dated at 2:30PM stating that "Resident was striked by another resident (Resident # 3) while in the courtyard". In the section titled 'Action taken to prevent recurrence', it stated, "Resident sent to the hospital for evaluation for . The police was contacted and visited. The aggressor was sent to the hospital crisis department for evaluation and medication management". A review of Resident # 3's health assessment revealed he was diagnosed with aggressive behavior, acute injury, and . The health assessment also stated that "the resident does not pose a danger to self or others (considering any significant history of physically or aggressive behavior). "	A 025		

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A 025	Continued From page 9 Further review of Resident # 3's records revealed a progress note dated stating that the resident was sent out to the hospital's crisis center for evaluation after altercation with another resident and displayed physical aggression. A second progress note dated stated the resident returned with no change in order. A review of the facility's records revealed an internal incident report dated at 2:30PM stating "Resident struck and shoved another resident (Resident # 2) for blowing smoke into his . . . . Both residents were sitting in the courtyard. Contacted Miami-Dade police. In the section titled 'Action taken to prevent recurrence', it stated, Miami - Dade Police contacted and visited. Resident was sent to hospital crisis for evaluation and treatment'. On at 2:46pm, the DON stated "In front of the cops I let him know that in no circumstances this is allowed. I told him that verbal communication is the most effective way to solve an issue and not take any action upon himself. After that, we sent him to Crisis for Evaluation. Informed the hospital of the incident and evaluation for behavior and possible adjustment to medications. Psych did not change anything for crisis. He does not have an assigned PCP. I'm unsure if he's had an . , . I would have to check." 3) On at 11:43am, observed Resident # 16 sitting in a wheelchair next to a large green plant chewing on a piece of leaf. The DON directed another staff member to pull Resident # 16 away from the plant and take Resident # 16 under the facility's courtyard tent.	A 025		

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A 025	Continued From page 10 A review of Resident # 16 records revealed a health assessment completed on and was diagnosed with ( ), , , Generalized , and . Resident # 16 was also wheelchair bound and was ordered to follow a and puree diet. 4) On at 4pm, observed 26 residents in the facility's courtyard/patio. 8 out of 26 residents were in a wheelchair while 3 out of 26 residents were observed using an assisted walking device. No staff were present. Class I	A 025		
A 027 SS=G	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making and remind residents about scheduled for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 027		

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A 027	Continued From page 11 failed to assist residents with arrangement for healthcare services for three out of 33 sampled residents (Resident # 1 - 3). Resident # 1 has been identified as "not feeling well" and acting unusually for at least 30 hours prior to the decision to take Resident # 1 to the hospital. Findings Included: 1) A review of Resident # 1's records showed she was admitted to the facility on [illegible] and a progress note dated [illegible] stating that Resident # 1 was sent to the hospital for evaluation for [illegible] and [illegible]. There was no documentation that the resident had extreme [illegible] and [illegible] of the fact. There was also no documentation that the resident had [illegible] or obtained any injury. Further review of Resident # 1's health assessment revealed she was diagnosed with Hyponatremia and [illegible]; however, hospital records revealed Resident # 1 was diagnosed with Hyponatremia, [illegible], [illegible], and [illegible] type [illegible]. On [illegible] at 2:50 pm, an interview with the Director of Nursing (DON) revealed that she received a call on [illegible] at around 9:30 am from one of the med techs because Resident # 1 did not look herself and appeared to be weak, [illegible], and disoriented. On [illegible] at 4:09 pm, Staff I stated that she saw Resident # 1 the day before the resident was sent to the hospital. Staff I stated that before her shift on [illegible] at 11 pm, the staff member she was	A 027		

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A 027	Continued From page 12 relieving, who had worked the pm shift, had told her to keep an on Resident # 1 because she was not feeling well. She stated that she was conducting rounds and found Resident # 1 sitting in the shower chair between 1 - 3 am and that it was unusual for Resident # 1 to take a shower so late at night. Staff I also stated, "I took her out of the shower to bed and noticed she was breathing fast". Staff I then stated that she called the DON twice and stated "I told the nurse to send her to the hospital and the nurse did not want to send her out right away and said to keep a close on her. I took her which was and the DON told me that it was normal and keep an on her to observe her a little more before sending her to the hospital". On at 10:31 am, the DON stated "They called me in the morning and said to me that she appeared to be and had a 90-degree hunchback. She was and . I wasn't here and everything was over the phone. I was told when the paramedics arrived that her were a little discolored and her was ". She also stated that "Fortunately, by the time they noticed the and discoloration, the paramedics were there so there was nothing more that we could have done since she's being sent to the hospital". At 12:54 pm, the DON stated that she did not contact a Primary Care Physician (PCP) when she was first told that Resident # 1 was feeling and weak between 1 - 3 AM (instead of 9:30 am as stated earlier). She also stated that she did not talk to a nurse or anyone. On at 10:50 am, Resident # 5 stated "I noticed Resident # 1 was not herself for a couple of days. She a day before she went to the hospital. She didn't have proper coordination and	A 027		

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A 027	Continued From page 13 I saw her . ". Resident # 5 also stated that approximately 2 days before she went to the hospital, Resident # 1 had . . . again while walking backwards and Resident # 5 called for an employee for help. Furthermore, Resident # 5 described Resident # 1's condition worsened and had to help Resident # 1 get up from the second time she had . He also stated that Staff HO noticed Resident # 1's . . . was . . . . Review of the facility's surveillance footage revealed Resident # 1's with . and showed Staff C had entered and left the room multiple times, leaving Resident # 1 unsupervised on the morning of . . . . . On . at 10 am, the Administrator stated that she got a call from the hospital and was told that she was being transported to the . . . unit because of a , "I'm not a nurse, but cross trained as one and a . . . . can cause discoloration and to the ". The Administrator also stated no investigation was conducted to find out what had happened to Resident # 1. Class II	A 027		
A 031 SS=G	58A-5.0182(7) FAC 429.255(1)(b). FS Resident Care - Third Party Services 58A-5.0182 (7) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, . . . , and paying for services provided by a third party of the resident's choice, including a licensed home	A 031		

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A 031	Continued From page 14 health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs. (c) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. 429.255(1)(b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s physician. However, the owner or administrator of the facility	A 031		

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A 031	Continued From page 15 shall be responsible for determining that the resident receiving services is appropriate for residence in the facility. This Statute or Rule is not met as evidenced by: Based on record A review and interview, the facility failed to coordinate with a third-party provider to maintain documentation of care provided to one out of 33 sampled residents (Resident # 4). This was evident by the failure to develop, implement, and document a facility policy for the coordination and oversight for third-party services from Resident #4 requiring care of a . Findings included: A review of Resident #4 records revealed Resident # 4 was admitted to the facility on . A health assessment dated revealed that the resident did not require any nursing services, was independent for toileting, and it did not indicate that the resident had a at the time of admission. Resident # 4's progress notes also showed no documentation that the resident had a at the time of admission. Further review of Resident # 4's records showed a prescription dated which stated 'Home Health nursing care for '. A review of Resident # 4's hospital records revealed a sheet dated which showed Resident # 4 was diagnosed with the following: unspecified , , essential , subcapsular polar age-related , age-related nuclear , prostatic hyperplasia with lower , tract symptoms, , unspecified nutritional deficiency,	A 031		

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A 031	Continued From page 16 [illegible] without [illegible], abnormalities of gait and mobility. A review of Resident # 4's progress notes showed a progress note completed on indicating that the resident was sent to the hospital for evaluation; it did not show why the resident had to be evaluated. A second progress note dated stated that the resident was in the facility's courtyard socializing pleasantly with no concerns. A third progress note dated stated the resident was sent to the hospital for evaluation and a change. The resident returned on the same day with no new orders. A review of hospital records in Resident #4's file showed he was prescribed - (DS) oral tablet on with instructions to take one tablet by twice a day for 10 days. Hospital discharge instructions dated indicated that the reason for visit was check or insertion and change. The discharge diagnoses were acute ( ) and ( ) change required. Follow up instructions stated that the resident needed to follow up with a Primary Care Physician (PCP) within days. There was also a referral dated for the resident to visit a urologist for retention since Resident # 4 had a . Additional records from the hospital revealed a prescription dated for the same medication DS oral tablet with instructions to take one tablet by twice a day for 10 days. Discharge instructions dated indicated that the reason for visit was and a penis. The resident	A 031		

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A 031	Continued From page 17 needed to follow up with a PCP within days. According to the American College of , - , (DS) is a combination of two and is used to treat , , , , traveler's , and pneumocystis carinii , . Additional hospital records showed that a doctor prescribed , 500 mg Oral Tablet on with instructions to take one tablet by every 12 hours for 10 days. Discharge instructions provided on from the hospital indicated that the reason for visit was 'checking tubing and '. The resident needed to follow up with a PCP within days for repeated testing and removal or replacement. The educational instructions indicated that the client had a and was treated with to prevent a more serious . The discharge summary included , Care instructions that stated the following: 'A , is a rubber tube that is placed through the (opening where comes out) and into the . This helps drain from the . There is a small balloon on the end of the tube that is inflated after insertion. This keeps the from sliding out of the '. According to the MedlinePlus, , is an use to treat certain including . On , the facility sent a note to the hospital in reference to Resident #4 indicating the reason for the visit. The note stated 'Please provide A' and 'resident has	A 031		

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A 031	Continued From page 18 complained of , at tip of penis near insertion site'. On , the facility sent another note to the hospital in reference to Resident #4 indicating the reason for the visit. The Director of Nursing (DON) completed the note which stated ' bag is leaking, please provide resident with to change and bag is also one month old'. Progress notes for Resident #4 did not indicate that the client had a until . There was no documentation that the resident went to the follow up with his primary care physician as recommended per the hospital discharge summary on and . On at 3:43 PM, the facility provided documents showing that care was provided on , , ,

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A 031	Continued From page 19 of admission". At 3:49 PM, the DON provided the name of the home health agency providing services to Resident #4. There was no documentation that Resident #4 received , care since date of admission to the facility on until . According to MedlinePlus, the use of can cause in the and . On at 11:42 AM, the Administrator stated that Resident #4 started with the home health agency on and remained active. The Administrator also stated the agency had a registered nurse (RN) and a licensed practical nurse (LPN) working on Resident # 4's case. Furthermore, the Administrator stated Resident # 4 started with , care on a daily basis and later at some point changed to , care every two or three weeks. Class II	A 031		
A 079 SS=G	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	A 079		

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A 079	Continued From page 20 66-75 457 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 , , ( ) 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	A 079		

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A 079	Continued From page 21 administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] 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	A 079		

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A 079	Continued From page 22 representatives. (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	A 079		

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A 079	Continued From page 23 hours are only counted once for the purpose of 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 interview and record review, the facility failed to maintain minimum staff hours per week to meet the scheduled and unscheduled needs of residents during the hours of 11 PM - 7AM. The facility had only three staff members taking care of 111 residents, including 31 residents who required assistance with of Activities of Daily Living (ADL). Findings included: A review of the facility's schedule for the month of [redacted] revealed only 3 staff members were scheduled to work from 11 PM - 7AM Monday - Sunday. Throughout the week of [redacted] - [redacted], one extra staff member is scheduled to train with another staff member on the 10th, 12th, and 13th of [redacted]. On [redacted] at 5:06 AM, Staff E stated that there were 111 residents living in the facility and only 3 staff members on duty at that time. On [redacted] at 6:02 AM, Staff M stated "downstairs is a lot to handle. I believe I have 8 residents or more that I provide personal direct care to from 11 PM - 7 PM". She also stated that she did not feel that there was enough staffing at night time to take care of the residents' needs.	A 079		

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A 079	Continued From page 24 On [redacted] at 6:25 AM, Staff E stated "I feel like there's not enough employees at night. On an average day at night, I have to provide direct care to 16 residents. Section C has the most. I'm usually able to get to everyone but will ask for help depending on the patient". She also stated that some of the residents needed adult briefs changed and some needed showers. On [redacted] at 6:49 AM, Staff I stated that there were not enough staffing at night time. She also stated that the first floor required more attention and more people that needs to be changed. On [redacted] at 7:12 am, Staff P stated "I feel like there's not enough employees. Some days we have 3 people: 1 in each section. Sometimes it's 4. When it's 3, it gets hectic for just one person. Section C (downstairs first floor) is more hectic than the other sections. They need more [redacted]-on care in Section C". A review of the facility's records revealed a document labeled 'Section C' which contained a list of a total of 38 residents living on the first floor. A review of the records for the 38 residents living on the first floor revealed: Resident # 20's heath assessment dated [redacted] showed diagnoses of [redacted] Precautions, and Legally [redacted]. Resident # 20 required assistance with ambulation, bathing, [redacted] and supervision with grooming. Resident # 21's health assessment dated [redacted] showed diagnoses of [redacted]	A 079		

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A 079	Continued From page 25 ( ), , and . Resident # 21 required assistance with ambulation, bathing, , grooming, toileting, and transferring. Resident # 22's health assessment dated showed diagnoses of Injury status post Motor Vehicle Accident (MVA), , Right , Spasms. Resident # 23 required assistance with ambulation, and supervision with bathing and grooming. Resident # 23's health assessment dated revealed she was diagnosed with , , , and . Resident # 24 required supervision with ambulation, bathing, , eating, grooming, toileting. Resident # 24's health assessment dated revealed he was diagnosed with , , , and history of . Resident # 25 required supervision with ambulation, bathing, , eating, grooming, toileting transferring. Resident # 25's health assessment dated revealed he was diagnosed with , and . Resident # 26 required supervision with bathing. Resident # 26's health assessment dated revealed she was diagnosed with Right , , infraction, , and . Resident # 27 required assistance with ambulation, bathing, , grooming, transferring and supervision with eating and toileting.	A 079		

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	AL11911412	A. BUILDING: _____ B. WING _____	09/30/2019

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A 079	Continued From page 26 Resident # 27's health assessment dated [redacted] revealed she was diagnosed with [redacted], and Gait. Resident # 27 required assistance with ambulation, bathing, [redacted], grooming, toileting, transferring. Resident # 28's health assessment dated [redacted] revealed she was diagnosed with [redacted], ulaphagmatic, [redacted], lymphedema, [redacted], and backache. Resident # 28 required assistance with ambulation, bathing, [redacted], eating, grooming, toileting and transferring. Resident # 29's health assessment dated [redacted] revealed he was diagnosed with [redacted], unsteady gait, and had precautions. Resident # 28 required assistance with ambulation, bathing, [redacted], grooming, toileting, transferring and supervision with eating. Resident # 30's health assessment dated [redacted] revealed she was diagnosed with [redacted] generalized [redacted], and [redacted]. Resident # 30 required assistance with ambulation, bathing, [redacted], transferring, and supervision with toileting. Resident # 31's health assessment dated [redacted] revealed he was diagnosed with [redacted] type II, essential [redacted], legally [redacted], and	A 079		

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A 079	Continued From page 27 . Resident # 31 required assistance with ambulation, bathing and transferring and supervision with bathing, grooming, eating, toileting. Resident # 32's health assessment dated revealed she was diagnosed with , and partially . Resident # 32 required assistance with ambulation, bathing, , eating, grooming, toileting and transferring. Resident # 33's health assessment dated revealed she was diagnosed with , and . Resident # 33 required assistance with ambulation, bathing, , eating, self care (grooming), toileting, and transferring. Resident # 7's health assessment dated revealed he was diagnosed with focal , severe , ( ), status post below , and . Resident # 7 required assistance with ambulation, bathing, , and transferring. Resident # 8's health assessment dated revealed he was diagnosed with , history of / , , Asphasia, , and . Resident # 7 required assistance with bathing, , and eating. Resident # 9's health assessment dated revealed she was diagnosed with	A 079		

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A 079	Continued From page 28 , baseline , Ventral , and overactive . Resident # 9 required assistance with ambulation, bathing, , self care (grooming), toileting, and transferring. Resident # 11's health assessment dated revealed he was diagnosed with , Tobacco Use, , and ( ). Resident # 11 required assistance with bathing, , and toileting. He also required total care with ambulation, self care (grooming), and transferring. Resident # 14's health assessment dated revealed he was diagnosed with history of arm gunshot , humerous shaft , history of state, , and collapse, type II , and hyponatremia. Resident # 14 required assistance with , toileting, and transferring. Resident # 1's health assessment dated revealed she was diagnosed with Hyponatremia and ( ) and required assistance with ambulation, bathing, , eating, self care (grooming), toileting, and transferring. Resident # 15's health assessment dated revealed she was diagnosed with 3 post ( ), , , , and . Resident # 15 required assistance with bathing, , self care (grooming), toileting, and transferring. Resident # 16's health assessment dated	A 079		

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A 079	Continued From page 29 revealed she was diagnosed with , ( ), , Generalized , and . Resident # 16 required assistance with ambulation, bathing, , eating, self care (grooming), toileting, and transferring. Resident # 17's health assessment dated revealed he was diagnosed with , without behaviors, and - . Resident # 17 required assistance with bathing, , and self care (grooming). Resident # 18's health assessment dated revealed she was diagnosed with ( ), , major , and . Resident # 18 required assistance with ambulation, bathing, , self care (grooming), toileting, and transferring. Resident # 19's health assessment dated revealed he was diagnosed with type, history of delay. Resident # 19 required assistance with bathing and self care (grooming). Class II	A 079		
A 152 SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS.	A 152		

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A 152	Continued From page 30 (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, or other furniture designed for storage of clothing or personal effects; 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility	A 152		

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A 152	Continued From page 31 failed to maintain a safe living environment and free of hazards. Findings included: On at 12:14 PM, observed a strong odor in # . At 12:17 PM, observed a strong odor in # as well. Both rooms shared the same bathroom. On at 12:17 PM, the Director of Nursing (DON) stated that she was going to look for housekeeping because of the strong smell. The housekeeper stated that it looked like the residents on the wall instead of inside the toilet. On at 12:19 PM, observed a cigarette odor in # . On at 12:19 PM, the DON stated that residents liked to smoke in their rooms. She also stated that the facility did not let them because of the fire risk, but residents would watch out for staff to avoid being caught smoking in their rooms. On at 5:20 AM, observed Staff I place her own shirt over her when entering # . There was a foul odor inside the room. At 5:21 AM, Staff I stated that she does not know why it smells so bad. On at 5:28 AM, observed a strong odor and a bucket under Resident # 19's bed. On at 5:30 AM, Staff I stated that since Resident # 19 is , he sometimes on the floor. She also stated that he did have a plastic , but he didn't use it.	A 152		

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A 152	Continued From page 32 Class III	A 152		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents	A 162		

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A 162	Continued From page 33 receiving assistance with the activities of daily living must have their ◡ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ... (. . .), CF-ES 1006, ... , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children	A 162		

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A 162	Continued From page 34 and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident ' s , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for	A 162		

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A 162	Continued From page 35 facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain an accurate health assessment showing the residents current medical history, diagnoses, and nursing services needed for one out of 33 sampled residents (Resident # 4). Findings included: 1) Review of Resident #4 records revealed Resident # 4 was admitted to the facility on . A health assessment dated revealed that the resident did not require any nursing services and did not state that the resident had a . The health assessment revealed a medical history and diagnoses of , (Prostatic Hyperplasia), , and history of ETOH ( ) use . The resident was independent for all activities of daily living including ambulation, bathing, , eating, self-care, toileting and transferring. A hospital sheet dated in Resident #4 records indicated Resident # 4 was diagnosed with the following: unspecified , , essential , subcapsular polar age-related , age-related nuclear , prostatic hyperplasia with lower , tract symptoms, , unspecified nutritional deficiency, without , abnormalities of gait and mobility.	A 162		

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A 162	Continued From page 36 Hospital records showed a discharge summary dated which stated that the reason for visit were ' check or insertion and change'. The discharge diagnoses were acute ( ) and ( ) change required. A second discharge summary dated showed that the reason for visit was and penis. The discharge diagnoses were and penis. A third discharge summary dated showed that the reason for visit was checking tubing and . The educational instructions indicated that the client had a . On at 3:29 PM, the Director of Nursing (DON) revealed that a third party provider provided the care to Resident #4's . At 3:32 PM, the DON stated, "Yes, he did have a at the time of admission". Class III	A 162		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond	A 165		

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A 165	Continued From page 37 quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.	A 165		

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A 165	Continued From page 38 (6) [redacted], neglect, or [redacted] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The	A 165		

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A 165	Continued From page 39 preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit an adverse incident report within 15 days of the incidents to the Agency for Healthcare Administration (AHCA) for three out of 33 sampled residents (Resident # 1 - 3). Resident # 1 was sent to the hospital for a change in behavior and . Upon arrival, Resident # 1 was found with grapefruit sized , to the left side of the , left shut, from the , and and to the right side of the . Resident # 2 was sent to the hospital with a black after being assaulted by Resident # 3. Resident # 3 had a history of aggressive behavior and local law enforcement was involved. Findings included: A review of Agency for Healthcare Administration (AHCA) Adverse Incident Report System (AIRS) revealed no reports filed for the facility in 2019. 1) A review of Resident # 1's records revealed a preliminary internal incident report dated at 12 PM with Resident # 1's name. The report showed Staff C was involved and the incident	A 165		

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	AL11911412	A. BUILDING: _____ B. WING _____	09/30/2019

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A 165	Continued From page 40 was reported by Staff Q. The report also revealed that Staff L and the Administrator were notified of the incident. Further review of the incident report revealed a summary stating 'Resident # 1 walked into the dining Room for breakfast she seemed disoriented and was walking with her down and seemed a bit . I called the Certified Nursing Assistant (CNA) on duty and informed her to keep an on Resident # 1 while I informed the Director of Nursing (DON) of her symptoms. DON suggested I call the non-emergency hot line. Resident had no the resident only seemed disoriented and , and had change in behavior'. A review of hospital records revealed Resident # 1 had to be transferred on from a local hospital to a unit due to a hematoma (associated with a ,). A final report stated "On arrival to the emergency department noted the patient has significant left-side , multiple and that appears to be 2 to 3-day old. The onset was unknown. The course/duration of symptoms is unknown". Hospital records also revealed a document from the facility labeled 'Notes for Hospital visitation' with Resident # 1's name, a checked section that stated 'Major change in behavior', and a section for additional notes that stated 'Major change in behavior and '. 2) On at 11:35 am, an interview with Resident # 2 revealed that he was recently in the hospital because he was punched in the by a resident. Resident # 2 stated that he does not recall who the resident was and does not remember much of what happened.	A 165		

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A 165	Continued From page 41 A review of the facility's records revealed an internal incident report dated at 2:30 PM stating that "Resident was striked by another resident (Resident # 3) while in the courtyard". In the section titled 'Action taken to prevent recurrence', it stated, "Resident sent to the hospital for evaluation for , . . The police was contacted and visited. The aggressor was sent to the hospital crisis department for evaluation and medication management". A review of the facility's records revealed an internal incident report dated . . . . . at 2:30 PM stating that "Resident struck and shoved another resident (Resident # 2) for blowing smoke into his . Both residents were sitting in the courtyard. Contacted Miami-Dade police. In the section titled 'Action taken to prevent recurrence', it stated, Miami - Dade Police contacted and visited. Resident was sent to hospital crisis for evaluation and treatment'. On . . . . . at 1:32 pm, the DON stated the administrator is responsible for reporting/filing adverse incident reports and that the administrator was aware of the altercation. On at 2:46 pm, the DON stated "In front of the cops I let him know that in no circumstances this is allowed. I told him that verbal communication is the most effective way to solve an issue and not take any action upon himself. After that, we sent him to Crisis for Evaluation. Informed the hospital of the incident and evaluation for behavior and possible adjustment to medications. Psych did not change anything for crisis. He does not have an assigned PCP. I'm unsure if he's had an . . . I would have to check."	A 165		

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A 165	Continued From page 42 Class III	A 165		

Agency for Health Care Administration

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CZ813 SS=D	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090(3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to keep a signed Attestation of Compliance with Background Screening Requirements form for four out of 22 sampled staff members (Staff E, G, I, and K). Findings included: Review of Staff I's personnel record revealed Staff I was hired on . . . and showed no documentation of a signed Attestation of Compliance with Background Screening Requirements form. Further review of Staff I's personnel records revealed the form was missing page # 4 where Staff I was supposed to have signed. Review of Staff K personnel record revealed Staff K was hired on and showed no evidence of a signed Attestation of Compliance with Background Screening Requirements form. Further review of Staff K's personnel records revealed the form was missing page # 4 where Staff K was supposed to have signed. On . . . . at 2:23 PM, the Assistant Administrator stated that the attestation form was	CZ813		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Agency for Health Care Administration

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CZ813	Continued From page 1 probably misplaced when the papers were filed. At 2:24 PM, she added that she needed to look for them. Review of Staff G's personnel record revealed Staff G was hired on and showed no documentation of a signed Attestation of Compliance with Background Screening Requirements form. Further review of Staff G's personnel records revealed the form was missing page # 4 where Staff G was supposed to have signed. On at 2:27 PM, the Assistant Administrator stated, "No, I don't find it. It is strange because the rest of the information is on record." Review of Staff E's personnel records revealed Staff E was hired on and showed no documentation of a signed Attestation of Compliance with Background Screening Requirements form. Further review of Staff E's personnel records revealed the form was missing page # 4 where Staff E was supposed to have signed. On at 2:29 PM, the Assistant Administrator stated that it was strange because the rest of the information was on record. Class III	CZ813		

Agency for Health Care Administration

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A 000	Initial Comments A complaint investigation (# 2019014679) was conducted at Livewell at Courtyard Plaza on and concluded on . Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=J	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services appropriate to meet the needs of four out of 33 sampled residents (Resident # 1 - 3 and # 16). Resident # 1 was sent to the hospital for a change in behavior and . Upon arrival, Resident # 1 was found with grapefruit sized , to the left side of the , left , shut, from the , and and to the right side of the . Resident # 2 was sent to the hospital with a black after being assaulted by Resident # 3. Resident # 3 had a history of aggressive behavior and there were no interventions in place to prevent recurrence of the incident. Resident # 16 was found to be unsupervised chewing on a facility's plant. Findings Included: 1) A review of the facility's admission and discharge log revealed Resident # 1 was admitted to the facility on and discharged on	A 025		

Agency for Health Care Administration

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A 025	Continued From page 2 On [redacted] at 1:32pm, when asked what the Director of Nursing (DON) knew about Resident # 1, she stated the resident was currently at the hospital. The DON had received a call from Staff Q on Sunday morning ([redacted]) at approximately 3 am. Staff Q had then reported to her that Resident # 1 was not herself. She continued to state that Staff Q described Resident # 1 as 'weak, as if she would [redacted] '. She was told by Staff Q that an aide had alerted her about the changes in Resident # 1's condition and instructed Staff Q to observe Resident # 1 throughout the day. The DON then stated that on the same day at approximately 9:30 am, Staff Q had called her a second time because Resident # 1's condition worsened. Staff Q had told her Resident # 1 was 'more weak, [redacted], and [redacted] '. She also stated that she had instructed Staff Q to call the non-emergency ambulance and that the paramedics had arrived at approximately 1 pm. Staff Q then told her that she had gone inside Resident # 1's room with the paramedics and found the resident lying in bed with blackish/blueish [redacted] and a [redacted]. Staff Q had reported to her that the change in Resident # 1's [redacted] happened within an hour time frame from the time the ambulance was called. A review of Resident # 1's records revealed a preliminary incident report dated [redacted] at 12 pm with Resident # 1's name. The report showed Staff C was involved and reported by Staff Q. The report also revealed that Staff L and the Administrator were notified of the incident. Further review of the report revealed a summary stating 'Resident # 1 walked into the dining Room for breakfast she seemed disoriented and was walking with her [redacted] down and seemed a bit	A 025		

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A 025	Continued From page 3 . I called the Certified Nursing Assistant (CNA) on duty and informed her to keep an on Resident # 1 while I informed the Director of Nursing (DON) of her symptoms. DON suggested I call the nonemergency hot line. Resident had no . The resident only seemed disoriented and and had change in behavior'. A review of hospital records revealed Resident # 1 was transferred on from a local hospital to a unit due to a hematoma (associated with a ,). A final report stated "On arrival to the emergency department noted the patient has significant left-side , multiple and that appears to be 2 to 3-day old. The onset was unknown. The course/duration of symptoms is unknown". A CT (Computed ,) Scan (described by the Mayo Clinic as a combination of images taken from different angles around the body which uses computer processing to create cross section images of tissues or bones) revealed the resident had significant and hematoma (solid of clotted within the tissues) on the left side of the extending from the frontal region of the to the (jaw). Further review of hospital records revealed Resident # 1 was diagnosed with displacement of lens, with loss of , and unspecified of bones. According to WebMD, a is a collection of outside of the and usually caused by severe injuries. Whereas, lens is a medical device , inside the to replace the 's natural lens when it is removed during surgery. According to the American Society of	A 025		

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A 025	Continued From page 4 , one of the causes for displacement of the lens is to the . Hospital records also revealed a document from the facility labeled 'Notes for Hospital visitation' with Resident # 1's name, a checked section that stated, 'Major change in behavior', and a section for additional notes that stated, 'Major change in behavior and '. An additional review of Resident # 1's records showed she was admitted to the facility on and an observation note dated stating that Resident # 1 was sent to the hospital for evaluation for and . There was no documentation that the resident had extreme and of the fact. There was also no documentation that the resident had or obtained any injury. Further review of Resident # 1's health assessment revealed she was diagnosed with Hyponatremia and ( ); however, hospital records revealed Resident # 1 was diagnosed with Hyponatremia, , ( ), and type . On at 2:48pm, Staff Q stated, "I noticed she was not herself, , breathing fast and not walking right". She also stated that she had contacted the DON to advise her that Resident # 1 was not feeling well and was told to check her . Staff Q then called the DON again to report the reading and the DON had told her "I will not send Resident # 1 to the hospital, just watch her". Furthermore, Staff Q stated "I saw Resident # 1 walk past me, she seemed a bit . Her posture was not the same. She walked hunched over, but this time	A 025		

Agency for Health Care Administration

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A 025	Continued From page 5 the hunch looked worse. The med tech and kitchen staff told me Resident # 1's diaper was slipping off. I tried to take her to the room to change her diaper. Resident # 1 did not want to go to her room and did not want to leave the dining room, she wanted to eat. Resident # 1 had no [illegible] on her [illegible]". Staff Q then added "When the ambulance came, I went to the room with paramedics and saw [illegible] on Resident # 1's [illegible]. I checked the surroundings, and nothing seemed like it was moved. I told the paramedics I thought it was an [illegible] reaction. When she came to the dining room, her [illegible] did not look like that". On [illegible] at 4:09pm, Staff I stated that she saw Resident # 1 the day before the resident was sent to the hospital. Staff I stated that before her shift on [illegible] at 11pm, the staff member she was relieving, who had worked the [illegible] pm shift, had told her to keep an [illegible] on Resident # 1 because she was not feeling well. Staff I further stated that she was conducting rounds and found Resident # 1 sitting in the shower chair between 1 - 3 am and said that it was unusual for Resident # 1 to take a shower so late at night. Staff I also stated, "I took her out of the shower to bed and noticed she was breathing fast". Staff I then stated that she called the DON twice. Staff I said "I told the nurse to send her to the hospital and the nurse did not want to send her out right away and said to keep a close [illegible] on her. I took her [illegible], which was [illegible] and the DON told me that it was normal and keep an [illegible] on her to observe her a little more before sending her to the hospital". A review of Staff Q's personnel files revealed a document titled 'Procedures for All Nursing Dept Staff'. The document stated, 'When an incident	A 025		

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A 025	Continued From page 6 occurs that requires paramedics or transport, one staff member must remain with the resident until they are transported out of the facility'. Review of the facility's surveillance footage revealed Resident # 1 with [illegible], and further showed Staff C had entered and left the room multiple times, leaving Resident # 1 unsupervised. On [illegible] at 10am, when asked if Resident # 1's [illegible] looked [illegible], the Administrator stated, "That's Resident # 1. I was told that she had a little [illegible], and a little discoloration". The Administrator also stated that she got a call from the hospital and was told that she was being transported to the [illegible] unit because of a [illegible], "I'm not a nurse, but cross trained as one and a [illegible] can cause discoloration and [illegible] to the [illegible]". The Administrator also stated no investigation was conducted to find out what had happened to Resident # 1. On [illegible] at 10:50am, Resident # 5 stated "I noticed Resident # 1 was not herself for a couple of days. She [illegible] a day before she went to the hospital. She didn't have proper coordination and I saw her [illegible]". Resident # 5 also stated that approximately 2 days before she went to the hospital, Resident # 1 had [illegible] again while walking backwards and Resident # 5 had called for an employee for help. Furthermore, Resident # 5 described Resident # 1's condition worsened and had to help Resident # 1 get up from the second time she had [illegible]. He also stated that he believed Staff H noticed Resident # 1's [illegible] was [illegible]. On [illegible] at 1:24pm, Staff C confirmed she worked on [illegible] and had taken care of Resident # 1. Staff C stated that she heard	A 025		

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A 025	Continued From page 7 Resident # 1 screamed out her name and ran to the room. Staff C had then left the room and waved down Staff A to come help her. Staff C was not able to explain what kind of assistance Resident # 1 was screaming for and did not understand why Resident # 1 screamed out her name. Staff C stated, "I did not go over to her"; however, she later stated that Resident # 1 was lying in bed when she arrived to the room. When asked if she noticed if Resident # 1 had any . . . . , or . . . . , to her . . . , she stated "no, she did not have anything on her ". On at 2:30pm, Staff A stated that Staff C had contacted her over the radio on . . . . to go to Resident # 1's room to see Resident # 1's because it was and . . . . She also stated that a resident had told her that Resident # 1 had . . . . In addition, Staff A stated that she had told Resident # 5 that Resident # 1's . . . weren't from the same day. On . . . . . at 10:55am, Staff H stated that she saw Resident # 1 the night before she went to the hospital. She was able to speak to the resident and stated Resident # 1 looked "perfect" and was laying down in bed. She also stated that she heard Resident # 1 had and that's why she was sent to the hospital. 2) On . . . . . at 11:35am, an interview with Resident # 2 revealed that he was recently in the hospital because he was punched in the . . . by a resident. Resident # 2 stated that he does not recall who the resident was and does not remember much of what happened. A review of Resident # 2's observation note dated	A 025		

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	AL11911412	A. BUILDING: _____ B. WING _____	09/30/2019

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A 025	Continued From page 8 showed that Resident # 2 was sent to the hospital after an altercation with another resident and an evaluation was requested. Additionally, there was a note for hospital visitation which stated that Resident # 2 had on the left side of his and lower . The note stated "Resident has complained of on the left side of the and after altercation with another resident striking and shoving him. Please evaluate". A second observation note dated stated that Resident # 2 returned to the facility with no change or orders provided, stable no concerns at this time. Further review revealed a health assessment which stated Resident # 2 was diagnosed with Early Onset , , and Type II . A review of hospital records revealed that Resident # 2 arrived there with a black . A review of the facility's records revealed an internal incident report dated at 2:30PM stating that "Resident was striked by another resident (Resident # 3) while in the courtyard". In the section titled 'Action taken to prevent recurrence', it stated, "Resident sent to the hospital for evaluation for . The police was contacted and visited. The aggressor was sent to the hospital crisis department for evaluation and medication management". A review of Resident # 3's health assessment revealed he was diagnosed with aggressive behavior, acute injury, and . The health assessment also stated that "the resident does not pose a danger to self or others (considering any significant history of physically or aggressive behavior). "	A 025		

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A 025	Continued From page 9 Further review of Resident # 3's records revealed a progress note dated stating that the resident was sent out to the hospital's crisis center for evaluation after altercation with another resident and displayed physical aggression. A second progress note dated stated the resident returned with no change in order. A review of the facility's records revealed an internal incident report dated at 2:30PM stating "Resident struck and shoved another resident (Resident # 2) for blowing smoke into his . . . . Both residents were sitting in the courtyard. Contacted Miami-Dade police. In the section titled 'Action taken to prevent recurrence', it stated, Miami - Dade Police contacted and visited. Resident was sent to hospital crisis for evaluation and treatment'. On at 2:46pm, the DON stated "In front of the cops I let him know that in no circumstances this is allowed. I told him that verbal communication is the most effective way to solve an issue and not take any action upon himself. After that, we sent him to Crisis for Evaluation. Informed the hospital of the incident and evaluation for behavior and possible adjustment to medications. Psych did not change anything for crisis. He does not have an assigned PCP. I'm unsure if he's had an . , . I would have to check." 3) On at 11:43am, observed Resident # 16 sitting in a wheelchair next to a large green plant chewing on a piece of leaf. The DON directed another staff member to pull Resident # 16 away from the plant and take Resident # 16 under the facility's courtyard tent.	A 025		

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A 025	Continued From page 10 A review of Resident # 16 records revealed a health assessment completed on and was diagnosed with ( ), , , , Generalized , and . Resident # 16 was also wheelchair bound and was ordered to follow a and puree diet. 4) On at 4pm, observed 26 residents in the facility's courtyard/patio. 8 out of 26 residents were in a wheelchair while 3 out of 26 residents were observed using an assisted walking device. No staff were present. Class I	A 025		
A 027 SS=G	58A-5.0182(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making and remind residents about scheduled for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 027		

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A 027	Continued From page 11 failed to assist residents with arrangement for healthcare services for three out of 33 sampled residents (Resident # 1 - 3). Resident # 1 has been identified as "not feeling well" and acting unusually for at least 30 hours prior to the decision to take Resident # 1 to the hospital. Findings Included: 1) A review of Resident # 1's records showed she was admitted to the facility on [illegible] and a progress note dated [illegible] stating that Resident # 1 was sent to the hospital for evaluation for [illegible] and [illegible]. There was no documentation that the resident had extreme [illegible] and [illegible] of the fact. There was also no documentation that the resident had [illegible] or obtained any injury. Further review of Resident # 1's health assessment revealed she was diagnosed with Hyponatremia and [illegible]; however, hospital records revealed Resident # 1 was diagnosed with Hyponatremia, [illegible], [illegible], and [illegible] type [illegible]. On [illegible] at 2:50 pm, an interview with the Director of Nursing (DON) revealed that she received a call on [illegible] at around 9:30 am from one of the med techs because Resident # 1 did not look herself and appeared to be weak, [illegible], and disoriented. On [illegible] at 4:09 pm, Staff I stated that she saw Resident # 1 the day before the resident was sent to the hospital. Staff I stated that before her shift on [illegible] at 11 pm, the staff member she was	A 027		

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A 027	Continued From page 12	A 027		

relieving, who had worked the pm shift, had told her to keep an on Resident # 1 because she was not feeling well. She stated that she was conducting rounds and found Resident # 1 sitting in the shower chair between 1 - 3 am and that it was unusual for Resident # 1 to take a shower so late at night. Staff I also stated, "I took her out of the shower to bed and noticed she was breathing fast". Staff I then stated that she called the DON twice and stated "I told the nurse to send her to the hospital and the nurse did not want to send her out right away and said to keep a close on her. I took her which was and the DON told me that it was normal and keep an on her to observe her a little more before sending her to the hospital".

On at 10:31 am, the DON stated "They called me in the morning and said to me that she appeared to be and had a 90-degree hunchback. She was and . I wasn't here and everything was over the phone. I was told when the paramedics arrived that her were a little discolored and her was ". She also stated that "Fortunately, by the time they noticed the and discoloration, the paramedics were there so there was nothing more that we could have done since she's being sent to the hospital". At 12:54 pm, the DON stated that she did not contact a Primary Care Physician (PCP) when she was first told that Resident # 1 was feeling and weak between 1 - 3 AM (instead of 9:30 am as stated earlier). She also stated that she did not talk to a nurse or anyone.

On at 10:50 am, Resident # 5 stated "I noticed Resident # 1 was not herself for a couple of days. She a day before she went to the hospital. She didn't have proper coordination and

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A 027	Continued From page 13 I saw her . ". Resident # 5 also stated that approximately 2 days before she went to the hospital, Resident # 1 had . . . again while walking backwards and Resident # 5 called for an employee for help. Furthermore, Resident # 5 described Resident # 1's condition worsened and had to help Resident # 1 get up from the second time she had . He also stated that Staff HO noticed Resident # 1's . . . was . . . . Review of the facility's surveillance footage revealed Resident # 1's with and showed Staff C had entered and left the room multiple times, leaving Resident # 1 unsupervised on the morning of . . . . . On . at 10 am, the Administrator stated that she got a call from the hospital and was told that she was being transported to the . . . unit because of a , "I'm not a nurse, but cross trained as one and a . . . . can cause discoloration and to the ". The Administrator also stated no investigation was conducted to find out what had happened to Resident # 1. Class II	A 027		
A 031 SS=G	58A-5.0182(7) FAC 429.255(1)(b). FS Resident Care - Third Party Services 58A-5.0182 (7) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, . . . , and paying for services provided by a third party of the resident's choice, including a licensed home	A 031		

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A 031	Continued From page 14 health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the resident's needs. (c) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. 429.255(1)(b) All staff in facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s physician. However, the owner or administrator of the facility	A 031		

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A 031	Continued From page 15 shall be responsible for determining that the resident receiving services is appropriate for residence in the facility. This Statute or Rule is not met as evidenced by: Based on record A review and interview, the facility failed to coordinate with a third-party provider to maintain documentation of care provided to one out of 33 sampled residents (Resident # 4). This was evident by the failure to develop, implement, and document a facility policy for the coordination and oversight for third-party services from Resident #4 requiring care of a . Findings included: A review of Resident #4 records revealed Resident # 4 was admitted to the facility on . A health assessment dated revealed that the resident did not require any nursing services, was independent for toileting, and it did not indicate that the resident had a at the time of admission. Resident # 4's progress notes also showed no documentation that the resident had a at the time of admission. Further review of Resident # 4's records showed a prescription dated which stated 'Home Health nursing care for '. A review of Resident # 4's hospital records revealed a sheet dated which showed Resident # 4 was diagnosed with the following: unspecified , , essential , subcapsular polar age-related , age-related nuclear , prostatic hyperplasia with lower , tract symptoms, , unspecified nutritional deficiency,	A 031		

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A 031	Continued From page 16 [illegible] without [illegible], abnormalities of gait and mobility. A review of Resident # 4's progress notes showed a progress note completed on indicating that the resident was sent to the hospital for evaluation; it did not show why the resident had to be evaluated. A second progress note dated stated that the resident was in the facility's courtyard socializing pleasantly with no concerns. A third progress note dated stated the resident was sent to the hospital for evaluation and a change. The resident returned on the same day with no new orders. A review of hospital records in Resident #4's file showed he was prescribed - (DS) oral tablet on with instructions to take one tablet by twice a day for 10 days. Hospital discharge instructions dated indicated that the reason for visit was check or insertion and change. The discharge diagnoses were acute ( ) and ( ) change required. Follow up instructions stated that the resident needed to follow up with a Primary Care Physician (PCP) within days. There was also a referral dated for the resident to visit a urologist for retention since Resident # 4 had a . Additional records from the hospital revealed a prescription dated for the same medication DS oral tablet with instructions to take one tablet by twice a day for 10 days. Discharge instructions dated indicated that the reason for visit was and a penis. The resident	A 031		

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A 031	Continued From page 17 needed to follow up with a PCP within days. According to the American College of , - , (DS) is a combination of two and is used to treat , , , traveler's , and pneumocystis carinii , . Additional hospital records showed that a doctor prescribed 500 mg Oral Tablet on with instructions to take one tablet by every 12 hours for 10 days. Discharge instructions provided on from the hospital indicated that the reason for visit was 'checking tubing and '. The resident needed to follow up with a PCP within days for repeated testing and removal or replacement. The educational instructions indicated that the client had a and was treated with to prevent a more serious . The discharge summary included Care instructions that stated the following: 'A is a rubber tube that is placed through the (opening where comes out) and into the . This helps drain from the . There is a small balloon on the end of the tube that is inflated after insertion. This keeps the from sliding out of the '. According to the MedlinePlus, is an use to treat certain including . On , the facility sent a note to the hospital in reference to Resident #4 indicating the reason for the visit. The note stated 'Please provide A' and 'resident has	A 031		

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A 031	Continued From page 18 complained of , at tip of penis near insertion site'. On , the facility sent another note to the hospital in reference to Resident #4 indicating the reason for the visit. The Director of Nursing (DON) completed the note which stated ' bag is leaking, please provide resident with to change and bag is also one month old'. Progress notes for Resident #4 did not indicate that the client had a until . There was no documentation that the resident went to the follow up with his primary care physician as recommended per the hospital discharge summary on and . On at 3:43 PM, the facility provided documents showing that care was provided on , , ,

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A 031	Continued From page 19 of admission". At 3:49 PM, the DON provided the name of the home health agency providing services to Resident #4. There was no documentation that Resident #4 received , care since date of admission to the facility on until . According to MedlinePlus, the use of can cause in the and . On at 11:42 AM, the Administrator stated that Resident #4 started with the home health agency on and remained active. The Administrator also stated the agency had a registered nurse (RN) and a licensed practical nurse (LPN) working on Resident # 4's case. Furthermore, the Administrator stated Resident # 4 started with , care on a daily basis and later at some point changed to , care every two or three weeks. Class II	A 031		
A 079 SS=G	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	A 079		

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A 079	Continued From page 20 66-75 457 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 , , ( ) 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	A 079		

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A 079	Continued From page 21 administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] 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	A 079		

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	AL11911412	A. BUILDING: _____ B. WING _____	09/30/2019

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A 079	Continued From page 22 representatives. (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	A 079		

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A 079	Continued From page 23 hours are only counted once for the purpose of 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 interview and record review, the facility failed to maintain minimum staff hours per week to meet the scheduled and unscheduled needs of residents during the hours of 11 PM - 7AM. The facility had only three staff members taking care of 111 residents, including 31 residents who required assistance with of Activities of Daily Living (ADL). Findings included: A review of the facility's schedule for the month of [redacted] revealed only 3 staff members were scheduled to work from 11 PM - 7AM Monday - Sunday. Throughout the week of [redacted], one extra staff member is scheduled to train with another staff member on the 10th, 12th, and 13th of [redacted]. On [redacted] at 5:06 AM, Staff E stated that there were 111 residents living in the facility and only 3 staff members on duty at that time. On [redacted] at 6:02 AM, Staff M stated "downstairs is a lot to handle. I believe I have 8 residents or more that I provide personal direct care to from 11 PM - 7 PM". She also stated that she did not feel that there was enough staffing at night time to take care of the residents' needs.	A 079		

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A 079	Continued From page 24 On [redacted] at 6:25 AM, Staff E stated "I feel like there's not enough employees at night. On an average day at night, I have to provide direct care to 16 residents. Section C has the most. I'm usually able to get to everyone but will ask for help depending on the patient". She also stated that some of the residents needed adult briefs changed and some needed showers. On [redacted] at 6:49 AM, Staff I stated that there were not enough staffing at night time. She also stated that the first floor required more attention and more people that needs to be changed. On [redacted] at 7:12 am, Staff P stated "I feel like there's not enough employees. Some days we have 3 people: 1 in each section. Sometimes it's 4. When it's 3, it gets hectic for just one person. Section C (downstairs first floor) is more hectic than the other sections. They need more [redacted]-on care in Section C". A review of the facility's records revealed a document labeled 'Section C' which contained a list of a total of 38 residents living on the first floor. A review of the records for the 38 residents living on the first floor revealed: Resident # 20's heath assessment dated [redacted] showed diagnoses of [redacted] Precautions, and Legally [redacted]. Resident # 20 required assistance with ambulation, bathing, [redacted] and supervision with grooming. Resident # 21's health assessment dated [redacted] showed diagnoses of [redacted]	A 079		

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A 079	Continued From page 25 ( ), , and . Resident # 21 required assistance with ambulation, bathing, , grooming, toileting, and transferring. Resident # 22's health assessment dated showed diagnoses of Injury status post Motor Vehicle Accident (MVA), , Right , Spasms. Resident # 23 required assistance with ambulation, and supervision with bathing and grooming. Resident # 23's health assessment dated revealed she was diagnosed with , , , , and . Resident # 24 required supervision with ambulation, bathing, , eating, grooming, toileting. Resident # 24's health assessment dated revealed he was diagnosed with , , , , and history of . Resident # 25 required supervision with ambulation, bathing, , eating, grooming, toileting transferring. Resident # 25's health assessment dated revealed he was diagnosed with , , and . Resident # 26 required supervision with bathing. Resident # 26's health assessment dated revealed she was diagnosed with Right , , infraction, , , and . Resident # 27 required assistance with ambulation, bathing, , grooming, transferring and supervision with eating and toileting.	A 079		

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A 079	Continued From page 26 Resident # 27's health assessment dated [redacted] revealed she was diagnosed with [redacted], and Gait. Resident # 27 required assistance with ambulation, bathing, [redacted], grooming, toileting, transferring. Resident # 28's health assessment dated [redacted] revealed she was diagnosed with [redacted], ulaphagmatic, [redacted], lymphedema, [redacted], and backache. Resident # 28 required assistance with ambulation, bathing, [redacted], eating, grooming, toileting and transferring. Resident # 29's health assessment dated [redacted] revealed he was diagnosed with [redacted], unsteady gait, and had [redacted] precautions. Resident # 28 required assistance with ambulation, bathing, [redacted], grooming, toileting, transferring and supervision with eating. Resident # 30's health assessment dated [redacted] revealed she was diagnosed with [redacted], generalized [redacted], and [redacted]. Resident # 30 required assistance with ambulation, bathing, [redacted], transferring, and supervision with toileting. Resident # 31's health assessment dated [redacted] revealed he was diagnosed with [redacted] type II, essential [redacted], legally [redacted], and	A 079		

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A 079	Continued From page 27 . Resident # 31 required assistance with ambulation, bathing and transferring and supervision with bathing, grooming, eating, toileting. Resident # 32's health assessment dated revealed she was diagnosed with , and partially . Resident # 32 required assistance with ambulation, bathing, , eating, grooming, toileting and transferring. Resident # 33's health assessment dated revealed she was diagnosed with , , and . Resident # 33 required assistance with ambulation, bathing, , eating, self care (grooming), toileting, and transferring. Resident # 7's health assessment dated revealed he was diagnosed with focal , severe , ( ), status post below , and . Resident # 7 required assistance with ambulation, bathing, , and transferring. Resident # 8's health assessment dated revealed he was diagnosed with , history of / , , Asphasia, , and . Resident # 7 required assistance with bathing, , and eating. Resident # 9's health assessment dated revealed she was diagnosed with ,	A 079		

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A 079	Continued From page 28 , baseline , Ventral , and overactive . Resident # 9 required assistance with ambulation, bathing, , self care (grooming), toileting, and transferring. Resident # 11's health assessment dated revealed he was diagnosed with , Tobacco Use, , and ( ). Resident # 11 required assistance with bathing, , and toileting. He also required total care with ambulation, self care (grooming), and transferring. Resident # 14's health assessment dated revealed he was diagnosed with history of arm gunshot , humerous shaft , history of state, , and collapse, type II , and hyponatremia. Resident # 14 required assistance with , toileting, and transferring. Resident # 1's health assessment dated revealed she was diagnosed with Hyponatremia and ( ) and required assistance with ambulation, bathing, , eating, self care (grooming), toileting, and transferring. Resident # 15's health assessment dated revealed she was diagnosed with 3 post ( ), , , , and . Resident # 15 required assistance with bathing, , self care (grooming), toileting, and transferring. Resident # 16's health assessment dated	A 079		

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A 079	Continued From page 29 revealed she was diagnosed with , ( ), , Generalized , and . Resident # 16 required assistance with ambulation, bathing, , eating, self care (grooming), toileting, and transferring. Resident # 17's health assessment dated revealed he was diagnosed with , without behaviors, and - . Resident # 17 required assistance with bathing, , and self care (grooming). Resident # 18's health assessment dated revealed she was diagnosed with ( ), , major , and . Resident # 18 required assistance with ambulation, bathing, , self care (grooming), toileting, and transferring. Resident # 19's health assessment dated revealed he was diagnosed with type, history of delay. Resident # 19 required assistance with bathing and self care (grooming). Class II	A 079		
A 152 SS=D	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS.	A 152		

Agency for Health Care Administration

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A 152	Continued From page 30 (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, or other furniture designed for storage of clothing or personal effects; 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility	A 152		

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A 152	Continued From page 31 failed to maintain a safe living environment and free of hazards. Findings included: On at 12:14 PM, observed a strong odor in # . At 12:17 PM, observed a strong odor in # as well. Both rooms shared the same bathroom. On at 12:17 PM, the Director of Nursing (DON) stated that she was going to look for housekeeping because of the strong smell. The housekeeper stated that it looked like the residents on the wall instead of inside the toilet. On at 12:19 PM, observed a cigarette odor in # . On at 12:19 PM, the DON stated that residents liked to smoke in their rooms. She also stated that the facility did not let them because of the fire risk, but residents would watch out for staff to avoid being caught smoking in their rooms. On at 5:20 AM, observed Staff I place her own shirt over her when entering # . There was a foul odor inside the room. At 5:21 AM, Staff I stated that she does not know why it smells so bad. On at 5:28 AM, observed a strong odor and a bucket under Resident # 19's bed. On at 5:30 AM, Staff I stated that since Resident # 19 is , he sometimes on the floor. She also stated that he did have a plastic , but he didn't use it.	A 152		

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A 152	Continued From page 32 Class III	A 152		
A 162 SS=D	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name; 2. ; 3. Race; 4. Date of birth; 5. Place of birth, if known; 6. Social security number; 7. Medicaid and/or Medicare number, or name of other health insurance ; 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in Rule 58A-5.0181, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider ' s order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 58A-5.020, F.A.C., if applicable. (e) The resident care record described in paragraph 58A-5.0182(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents	A 162		

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A 162	Continued From page 33 receiving assistance with the activities of daily living must have their ◡ recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 58A-5.0181, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 58A-5.0185, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 58A-5.025, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ... (. . .), CF-ES 1006, ... , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children	A 162		

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A 162	Continued From page 34 and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 58A-5.0181, F.A.C. (o) The resident ' s , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement; 2. The resident demographic data required in this paragraph; 3. The health assessment described in Rule 58A-5.0181, F.A.C.; 4. The resident's contract described in Rule 58A-5.025, F.A.C.; and 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for	A 162		

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A 162	Continued From page 35 facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 58A-5.029, 58A-5.030 and 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to obtain an accurate health assessment showing the residents current medical history, diagnoses, and nursing services needed for one out of 33 sampled residents (Resident # 4). Findings included: 1) Review of Resident #4 records revealed Resident # 4 was admitted to the facility on . A health assessment dated revealed that the resident did not require any nursing services and did not state that the resident had a . The health assessment revealed a medical history and diagnoses of , (Prostatic Hyperplasia), , and history of ETOH ( ) use . The resident was independent for all activities of daily living including ambulation, bathing, , eating, self-care, toileting and transferring. A hospital sheet dated in Resident #4 records indicated Resident # 4 was diagnosed with the following: unspecified , , essential , subcapsular polar age-related , age-related nuclear , prostatic hyperplasia with lower , tract symptoms, , unspecified nutritional deficiency, without , abnormalities of gait and mobility.	A 162		

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	AL11911412	A. BUILDING: _____ B. WING _____	09/30/2019

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A 162	Continued From page 36 Hospital records showed a discharge summary dated which stated that the reason for visit were ' check or insertion and change'. The discharge diagnoses were acute ( ) and ( ) change required. A second discharge summary dated showed that the reason for visit was and penis. The discharge diagnoses were and penis. A third discharge summary dated showed that the reason for visit was checking tubing and . The educational instructions indicated that the client had a . On at 3:29 PM, the Director of Nursing (DON) revealed that a third party provider provided the care to Resident #4's . At 3:32 PM, the DON stated, "Yes, he did have a at the time of admission". Class III	A 162		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond	A 165		

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A 165	Continued From page 37 quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. [illegible]; 2. [illegible] or [illegible] damage; 3. Permanent [illegible]; 4. [illegible] or [illegible] of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.	A 165		

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A 165	Continued From page 38 (6) [redacted], neglect, or [redacted] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The	A 165		

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A 165	Continued From page 39 preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit an adverse incident report within 15 days of the incidents to the Agency for Healthcare Administration (AHCA) for three out of 33 sampled residents (Resident # 1 - 3). Resident # 1 was sent to the hospital for a change in behavior and . Upon arrival, Resident # 1 was found with grapefruit sized , to the left side of the , left shut, from the , and and to the right side of the . Resident # 2 was sent to the hospital with a black after being assaulted by Resident # 3. Resident # 3 had a history of aggressive behavior and local law enforcement was involved. Findings included: A review of Agency for Healthcare Administration (AHCA) Adverse Incident Report System (AIRS) revealed no reports filed for the facility in 2019. 1) A review of Resident # 1's records revealed a preliminary internal incident report dated at 12 PM with Resident # 1's name. The report showed Staff C was involved and the incident	A 165		

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A 165	Continued From page 40 was reported by Staff Q. The report also revealed that Staff L and the Administrator were notified of the incident. Further review of the incident report revealed a summary stating 'Resident # 1 walked into the dining Room for breakfast she seemed disoriented and was walking with her down and seemed a bit . I called the Certified Nursing Assistant (CNA) on duty and informed her to keep an on Resident # 1 while I informed the Director of Nursing (DON) of her symptoms. DON suggested I call the non-emergency hot line. Resident had no the resident only seemed disoriented and , and had change in behavior'. A review of hospital records revealed Resident # 1 had to be transferred on from a local hospital to a unit due to a hematoma (associated with a ,). A final report stated "On arrival to the emergency department noted the patient has significant left-side , multiple and that appears to be 2 to 3-day old. The onset was unknown. The course/duration of symptoms is unknown". Hospital records also revealed a document from the facility labeled 'Notes for Hospital visitation' with Resident # 1's name, a checked section that stated 'Major change in behavior', and a section for additional notes that stated 'Major change in behavior and '. 2) On at 11:35 am, an interview with Resident # 2 revealed that he was recently in the hospital because he was punched in the by a resident. Resident # 2 stated that he does not recall who the resident was and does not remember much of what happened.	A 165		

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A 165	Continued From page 41 A review of the facility's records revealed an internal incident report dated at 2:30 PM stating that "Resident was striked by another resident (Resident # 3) while in the courtyard". In the section titled 'Action taken to prevent recurrence', it stated, "Resident sent to the hospital for evaluation for , . . The police was contacted and visited. The aggressor was sent to the hospital crisis department for evaluation and medication management". A review of the facility's records revealed an internal incident report dated . . . . at 2:30 PM stating that "Resident struck and shoved another resident (Resident # 2) for blowing smoke into his . Both residents were sitting in the courtyard. Contacted Miami-Dade police. In the section titled 'Action taken to prevent recurrence', it stated, Miami - Dade Police contacted and visited. Resident was sent to hospital crisis for evaluation and treatment'. On . . . . . at 1:32 pm, the DON stated the administrator is responsible for reporting/filing adverse incident reports and that the administrator was aware of the altercation. On at 2:46 pm, the DON stated "In front of the cops I let him know that in no circumstances this is allowed. I told him that verbal communication is the most effective way to solve an issue and not take any action upon himself. After that, we sent him to Crisis for Evaluation. Informed the hospital of the incident and evaluation for behavior and possible adjustment to medications. Psych did not change anything for crisis. He does not have an assigned PCP. I'm unsure if he's had an . . . I would have to check."	A 165		

Agency for Health Care Administration

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A 165	Continued From page 42 Class III	A 165		