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
	AL11965917	A. BUILDING: _____ B. WING _____	06/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABOT COVE ASSISTED LIVING LLC	455 BELCHER RD S LARGO, FL 33771

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A licensure complaint survey (complaint #2022005805) was conducted at Cabot Cove Assisted Living LLC on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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	A 025		

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A 025	Continued From page 1 59A-36.012, 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. (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 records review, the facility failed to provide supervision to prevent an elopement for 1 of 1 (Resident #1). Findings Included: On . . . , a review of an incident report revealed Resident #1 had eloped from the facility on . . . . . Resident #1 walked out of the front door of the facility and the facility staff was not aware that the resident was missing until two unknown persons returned him to the facility after finding him standing on a busy street corner.	A 025		

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A 025	Continued From page 2 An interview with Staff C, at 10:30am on [redacted], revealed she was the receptionist of the facility and was charged with ensuring that all residents sign out and in when they left the building. The facility did not have a secure memory care facility. Residents who were elopement risks wore [redacted] guard bracelets, that would alert the staff, if they left the building through a door. Resident #1 did not wear a [redacted] guard, prior to his elopement. He would often sit in the front of the building in the reception area, near the front door, and ask if he could go outside. Sometimes, she said, he would get upset when they told him he could not go outside. She stated that the facility had a receptionist working every day of the week, but the hours were only during daytime hours, as scheduled. The facility was toured at 11:00am on [redacted] and it was observed that the facility did not have a secure memory care unit, however there were 3 exit doors, 2 were fire emergency doors with alarms on them and the 3rd, the front door, with was monitored by a receptionist. A sign in and sign out book was observed near the door, and the receptionist was observed asking residents to sign out as they were leaving. A review of the facility's elopement prevention policy and procedure, on , revealed that the facility would assess all residents upon admission, and periodically, in order to develop an appropriate service plan that would ensure the resident's safety. They would also use an appropriate [redacted] control device, if needed. A review of Resident #1's record on [redacted] revealed that he was admitted to the facility on [redacted]. The only 1823 health assessment in the record that was signed and dated by a healthcare	A 025		

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A 025	Continued From page 3 provider was dated ..... and was missing pertinent, required information, such as: physical or sensory limitations, special precautions, elopement risk status and medication assistance needs. The records also did not contain any completed elopement risk assessment tool for the resident. An interview with the acting Administrator was conducted at 1:30pm and, when asked about Resident 1's 1823 health assessment, with missing elopement risk status, agreed that the facility should have had it, as well as it should have completed an elopement risk assessment for the resident. Photographic evidence obtained. Class III	A 025		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) ..... AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , . and , . shall satisfy this requirement. Facility staff who	A 086		

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A 086	Continued From page 4 meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which	A 086		

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A 086	Continued From page 5 meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related . . . ," dated . . . . . , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or 2. Three years of practical experience in a program providing care to persons with . . . . . or related . . . . . , or 3. Completed a specialized training program in the subject matter of this program and have a	A 086		

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A 086	Continued From page 6 minimum of two years of practical experience in a program providing care to persons with [redacted] or related [redacted]. (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on observation, records review and interview, the facility, that advertised they provide special care for persons with [redacted] 's [redacted] and related [redacted] (ADRD), failed to ensure that 2 of 3 facility staff (Staff A and the Resident Care Coordinator), whose records were reviewed, received the appropriate training. Findings Included: Upon arrival to the facility at 10:00am on [redacted], it was observed that the monument sign in front of the facility stated the facility's name and it said "memory care". On [redacted], a review of Staff A's training record revealed that she was hired on [redacted]. The record revealed that she did not complete the required ADRD Level 1 training until [redacted], even though the training was required by the 3rd month of employment, on [redacted], therefore it was more than 4 months late. On [redacted], a review of the Resident Care Coordinator's training records revealed that she had been working in the facility since [redacted] and	A 086		

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A 086	Continued From page 7 the only documentation of ADRD training in the record was a 4 hour ADRD annual update certificate dated . . . . Missing were the 4 hour ADRD Level 1 and ADRD Level 2 certificates that would have been required within 9 months of her starting dated on . An interview with Staff C, at 12:45pm on , was conducted regarding the contents of the staff training files that were reviewed. She stated that the files were complete and there was nothing left to add to them. Class III	A 086		
A 162 SS=D	59A-36.015(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 59A-36.006, F.A.C. (c) Any orders for medications, nursing services,	A 162		

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A 162	Continued From page 8 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 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(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 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 59A-36.006, 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 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, 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.	A 162		

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A 162	Continued From page 9 (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 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 59A-36.006, 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 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic	A 162		

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A 162	Continued From page 10	A 162		

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 facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure that 1 of 1 residents' records(Resident #1), that were reviewed, contained the required assessment data to determine if the resident's needs could be met by the facility.

Findings Included:

A review of the facility's elopement prevention policy and procedure on revealed that the facility stated it would assess all potential residents, upon admission, for their elopement risk status, and again periodically as needed, in order to develop an appropriate service plan that would ensure the resident's safety.

A review of Resident #1's record on revealed that he was admitted to the facility on . The only 1823 health assessment signed and dated by a healthcare provider, was dated

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A 162	Continued From page 11 . . . . . and was missing pertinent, required information, such as; physical or sensory limitations, special precautions, elopement risk status and medication assistance needs. The record also did not contain any completed elopement risk assessment tool for the resident. There was no documentation in the resident's record that he was an elopement risk, other than the diagnoses of . . . . . , and that he was occasionally , . . . and experienced some . . . . . . On . . . . . , a review of an adverse incident report, filed with the agency, regarding an elopement from the facility by Resident #1 on , revealed that Resident #1 walked out of the front door of the facility and the facility was not aware that the resident was missing until 2 unknown persons returned him to the facility, after finding him standing on a busy street corner. An interview with Staff C at 10:30am on revealed she was the receptionist of the facility and was charged with ensuring that all residents sign out, and . . . . in, when they leaving the building. The facility did not have a secure memory care unit. Residents who were elopement risks wore guard bracelets that would alert the staff if they left the building through a door. Resident #1 was not considered to be an elopement risk until after he eloped on . An interview with the acting administrator was conducted at 1:30pm and, when asked about Resident 1's 1823 health assessment, with missing elopement risk status, agreed that the facility should have had it, as well as it should have completed an elopement risk assessment for the resident.	A 162		

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A 162	Continued From page 12 Photographic evidence obtained. Class III	A 162		