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
	AL11965658	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM COTTAGES OF ROCKLEDGE	3821 SUNNYSIDE COURT ROCKLEDGE, FL 32955

(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 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response	A 032		

AHCA Form 3020-0001

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

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A 032	Continued From page 1 Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on the facility's documentation, resident record review and interview, the facility failed to make, at a minimum, a daily effort to determine residents who are at risk of elopement have identification on their persons that includes their name, facility's name, facility's address, and facility's telephone number as required for 1 of 5 sampled residents (5). Findings: The facility's elopement policies and procedures does not have all required components in the policy such as making a daily effort to ensure that a resident at risk for elopement has identification on their persons.	A 032		

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A 032	Continued From page 2 (Photographic Evidence Obtained) Resident #5's record revealed an admission date of . . . . . The last 1823 Health Assessment dated listed medical history of . . . . . history of and . . . . The resident was identified as an elopement risk. She needs assistance with self-administration of medication, and she needs supervision with bathing. On at 1:30 PM, an interview with the Administrator confirmed the findings. Class III	A 032		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to	A 056		

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A 056	Continued From page 3 another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . . . , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled	A 056		

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A 056	Continued From page 4 or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a medication was filled in a timely manner for 1 of 5 sampled residents who received assistance with self-administration of medications (#7). Findings: During an interview with resident #7 on [redacted] at 10:50 A.M., she said that the facility oftentimes ran out of her " [redacted] medicine".	A 056		

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A 056	Continued From page 5 On [redacted] a review of resident #7 Health Assessment form (1823) revealed she needed assistance with self-administration of medication. On [redacted] a review of resident #7 Medication Observation Record (MOR) for [redacted] was conducted. The review revealed omissions for [redacted] 137mcg at 6am on [redacted], and [redacted]. Further review of the MOR revealed documentation that the medication was not available. On [redacted] at 2:40pm during an interview, the Resident Care Director confirmed the facility ran out of resident #7 [redacted] causing her to miss 3 doses. Class III	A 056		
AE210 SS=D	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to [redacted], shall not be required to take the assisted living facility core training competency test. (b) The administrator and the ECC supervisor, if different from the administrator, must complete a	AE210		

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AE210	Continued From page 6 minimum of 4 hours of continuing education every two years in topics relating to the physical, [illegible], or social needs of frail elderly and persons, or persons with 's or related . (c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility. This Statute or Rule is not met as evidenced by: Based on record review and interview the administrator failed to complete 4 hours of Extended Congregated Care (ECC) continuing education as required in Statue 58A-5.0191(7) FAC. Findings In a record review on of the administrator's personnel record it revealed the last 4 hour required ECC continuing education class completed was in . In an interview on at 2pm, the administrator confirmed the findings. PHOTOGRAPHIC EVIDENCE OBTAINED Class III	AE210		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse	CZ814		

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CZ814	Continued From page 7 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on review of the Background Screening (BGS) Employee Roster, personnel record review and interview, the facility failed to ensure that 1 of 7 sampled staff (A) correct employment status was reported on the clearinghouse within 10 business days of employment. Findings:	CZ814		

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CZ814	Continued From page 8 Reviewed the Background Screening (BGS) Employee Roster on at 12:30 PM, showing result that Med Tech staff A was hired on and listed twice with a termination end date and termination end date . (Photographic Evidence Obtained) Med Tech staff A's personnel record review revealed hire date . The Level 2 BGS screening eligibility results dated was on file. On at 11:10 AM, an interview with Med Tech staff A stated that she was rehired last month . She was also observed working the memory care cottage (Queen building) and was scheduled to work today at 6:45 AM-3 PM verified by review of the staff work schedule. On at 1 PM, an interview with the Administrator confirmed the finding. Unclassified	CZ814		
A 000	Initial Comments RELICENSURE A relicensure and generator monitoring was conducted on at Palm Cottages of Rockledge. Deficiencies were found at the time of the visit.	A 000		
A 004 SS=D	59A-36.004 FAC Licensure - Requirements 59A-36.004 License Requirements. (1) SERVICE PROHIBITION. An assisted living	A 004		

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A 004	Continued From page 9	A 004		

facility may not represent that it provides any service other than a service for which it is licensed to provide.
(2) CHANGE IN USE OF SPACE REQUIRING AGENCY CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility's capacity must not be made without prior approval from the Agency Central Office. Approval must be based on the compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection requirements referenced in Rule 59A-36.005, F.A.C.
(3) CHANGE IN USE OF SPACE REQUIRING AGENCY FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, must not be made without prior approval from the Agency Field Office. Approval must be based on compliance with the physical plant standards provided in Rule 59A-36.014, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation inspection standards referenced in Rule 59A-36.005, F.A.C.
(4) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. "Contiguous property" means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Chapters 408, Part II, 429, Part I, F.S. and rule Chapter 59A-35, F.A.C., and this rule chapter.

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A 004	Continued From page 10 (5) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 59A-36.005, F.A.C., must be submitted annually to the Agency Central Office. The annual inspections must be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Chapter 408, part II, and Section 429.14, F.S., and rule Chapter 59A-35, F.A.C. (6) RESIDENTS RECEIVING STATE-FUNDED SERVICES. Upon request, the facility administrator or designee must identify residents receiving state-funded services to the agency and the department for monitoring purposes authorized by state and federal laws. This Statute or Rule is not met as evidenced by: Based on interviews and observations, the facility failed to report to the agency the kitchens in 2 of the 6 buildings were under renovations and were not being used to prepare meals for the residents in Date Cottage and Sylvester Cottage. Findings: On _____ at 11am during a tour of the Date cottage the kitchen was in the process of being renovated. There was a large tarp suspended from the ceiling surrounding the kitchen area. On _____ at 11:20am during a tour of the Sylvester cottage, the kitchen was in the process of being renovated. There was a large tarp suspended from the ceiling surrounding the kitchen. At 11:25am Staff H said the renovation had been going on for about 2 weeks. The meals are being prepared in the cottage across from them. She	A 004		

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A 004	Continued From page 11 said there was a refrigerator with snacks and drinks set up in one of the vacant rooms. On at 1pm, the administrator stated she did not report the renovations to the agency and all the cottage kitchens will be going under renovations at some point. (Photo evidence obtained) Class III	A 004		
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	A 025		

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A 025	Continued From page 12 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 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 record reviews and interviews, the facility failed to follow a health care provider's medication order for 1 of 5 sampled residents (#7). Findings: Review of resident #7's record revealed a facility	A 025		

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A 025	Continued From page 13 admission date of . . . . . . The resident's medical diagnoses were ,, , ... type 2, valve , ... An 1823, dated . . . . . , indicated the resident required assistance with self-administration of medications. During an interview with resident #7 on . . . . . at 10:50 A.M., the resident said that she had a procedure approximately two weeks prior and as a result, the doctor ordered to increase the resident's . . . . . from 20 milligrams (mg) daily to 40 mg twice a day. The resident said that despite the order, the facility did not give her the 40 mg dose until that morning. During an interview with resident #7 with both the director of nursing and the administrator on at 2:15 P.M., the resident again said that despite the facility having the 40 mg . . . . . tablets available for approximately one week, she was not given the first dose until that morning. Review of the . . . . . 40 mg package that was in the medication cart revealed it was delivered to the facility on . . . . . "Clarifying order. Computer says 20 mg" was handwritten on the package. Only one tablet was missing, and the , medication observation record (MOR) indicated the medication was not signed as given for the first time until that morning. Continued review of the resident's record revealed there was no documentation to indicate what steps the facility made to clarify the order when the medication was delivered on to ensure the resident received it in a timely manner.	A 025		

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
	AL11965658	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALM COTTAGES OF ROCKLEDGE	3821 SUNNYSIDE COURT ROCKLEDGE, FL 32955

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A 025	Continued From page 14 Class III	A 025		