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 _____	06/21/2023

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 000	Initial Comments A complaint investigation #2023003896 and #2023007773 was conducted a t Palm Cottages on and . The facility had deficiencies at the time of the visit.	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 observations, record reviews and interviews, the facility failed to follow a health care provider's recommended order by not giving a medication to 1 of 4 sampled residents (#1) and failed to follow its policy on incident reporting by failing to complete an incident report for 2 of 4 sampled residents who sustained an injury (#1 and #3). Findings: 1. Review of resident #1's record revealed a facility admission date of . Her medical history included moderate to severe . She required assistance with self-administration	A 025		

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A 025	Continued From page 2 of medications. Both a and 1823 health assessment forms had the statements "I would advise starting 5 milligrams (mg) by daily x2 weeks then increase to 5 mg twice daily once patient is acclimated" "feel free to call with any questions or concerns". Review of her through medication observation records (MORs) revealed no documentation to indicate she ever received . Review of her record revealed no documentation to indicate the facility contacted either the provider who completed the 1823s or the provider who treated her at the facility to discuss giving the medication. On a health care provider ordered 25 mg twice daily. On a health care provider ordered an increase in the to 50 mg three times daily, hold for . On a health care provider ordered an increase in the to 75 mg three times daily. On a health care provider discontinued the per a request from the resident's family. On at 4:23 pm the resident had and on the top of her left . She complained of when the area was touched. "No record of injury or ". An advanced practice registered nurse (APRN) was notified. On at 3:18 am she ambulated around the unit with no evidence of . Her left	A 025		

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A 025	Continued From page 3 remained . . . . . She was encouraged to rest and elevate her . She replied, "shut up". On a health care provider ordered a left . . . . . . On . . . . . at 3:45 pm the mobile . company had still not arrived. Her daughter came to the facility and said this was ridiculous and she was going to take her to medfast for an . The resident had been walking around the cottage all day with no complaints of . 10:53 am the director of nursing (DON) spoke with her daughter because the resident had not returned. Her daughter said she would not be returning her mom because it took over 24 hours to get an . She said her mother did have a . . . . . and we needed to figure out how it happened. It was explained to her that the doctor was notified of the . . . . right away. An order was received the next morning and the . was ordered as soon as the facility received the order, but they could not control what time the . was completed by the third party. She then said that the facility should have done something. The DON explained that the resident could have been sent out for an but there was no signs of . or distress. On . . . . . at 4 pm, when asked if the facility conducted an investigation into the cause of the . . . injury, the administrator said an incident report was not completed. On at 9 am, when asked again about an investigation into the . . . injury, the administrator replied, "what you have there is what we've got". No documentation was provided to indicate an investigation was conducted.	A 025		

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A 025	Continued From page 4 On at 9:15 am, the administrator confirmed the findings regarding the . On at 9:23 am, the resident's daughter said no one discussed adding the , with her and she learned of it only after it had already been given. There was no documentation in the resident's record to indicate anyone from the facility notified her daughter of the . On at 10:23 am, the APRN who prescribed the , said he did not first discuss it with the resident's daughter. He said notification of medication changes were usually done by the facility. He said the facility never asked him about the recommendation for . On at 1:50 pm, the DON said she typically reviews admission 1823s, but she did not remember seeing the recommendation on the resident's 1823s. On at 2:20 pm, the DON said an investigation into the injury was not conducted because "she gets up and walks around. There was kind of like an explanation. She showed no signs of distress, so we never sent her to the hospital and her daughter came and took her to Medfast". 2. Review of resident #3's record revealed a facility admission date of . Her medical history included ( ), D deficiency and . She was alert and oriented only to self.	A 025		

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A 025	Continued From page 5 On at 6:18 pm, a caregiver found her in bed with a on her right . She was unable to explain how it occurred. On at 4 pm, a request was made to review the incident report for the found on . The administrator said an incident report was not completed. The facility's policy on incident reports read, in part, the unusual incident form is used to document and report an incident which is a threat to a resident's health, safety, welfare, or rights. This includes but is not limited to occurrences such as: , injury, , discolorations, , crisis, unexplained absence, any violation of resident rights, any incident that threatens the health, welfare, or safety of the resident. Class III	A 025		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or	A 033		

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A 033	Continued From page 6 function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical . . . . annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical . . . . and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to obtain for 1 of 1 resident a prescribed order by a physician for the use of a physical and a written care plan (#4). Findings: In review of Resident #4 . . . . . 1823 did not reveal the use of a physical . . . or written care plan. On . . . . . 1:01pm - The administrator was unable to provide an individual policy for . . . . . and assistive devices. The administrator stated, "they don't have anything other than whatever we go over in training". On . . . . . at 2:11pm - The Administrator stated, the daughter brought in the wheelchair with the belt attached. I would have to go check her records for orders. "We don't allow physical . . . . . ". On . . . . . at 2:11pm The Caregiver stated, "the daughter told the staff to use so she would	A 033		

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A 033	Continued From page 7 not . out". On ..... at 2:17pm - The Administrator and Resident Care Director stated the chair came in about a week ago or so, it was very recent that the daughter brought the chair. Class III	A 033		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment. (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to have policies and procedures that included the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and	A 034		

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A 034	Continued From page 8 procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. Findings: On . . . . . at 10:35 am, resident #4 was seen sitting in a transport wheelchair in the common area with a seat belt attached around her waist. When asked if she could remove it, she replied "no". Three-quarter side rails were seen on her bed. On at 2:50 pm, she was seen in her bed with her . , . . closed. Both of the side rails were up. On at 1:01 pm, a request was made of the administrator to provide the facility's policy on assistive devices. She replied that the facility did not have a policy. Class III	A 034		
A 052 SS=D	429.256(.); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . . . syringe that is prefilled with the proper dosage by a pharmacist and an . . . . , . . . that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming	A 052		

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A 052	Continued From page 9	A 052		

that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.
(c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .
(d) Applying , medications.
(e) Returning the medication container to proper storage.
(f) Keeping a record of when a resident receives assistance with self-administration under this section.
(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .
(4) Assistance with self-administration of medication does not include:
(a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications by way of a tube inserted in a of the body.

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A 052	Continued From page 10 (d) Administration of , , , , , , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally	A 052		

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A 052	Continued From page 11	A 052		

advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed

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A 052	Continued From page 12 in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's [illegible] control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, interview, and record review the facility failed to ensure 2 of 2 residents received assistance with self-administration. (#8 & #9) Findings: 1. Review of resident #8's 1823 revealed she required assistance with self-administration of medications. On at 10:53am - Resident #8 was observed in her room and numerous unsecured medications were identified. The resident stated the facility does her medications. The medications identified were: Voltaren, Ultimate Probiotic Formula, [illegible] Extra Strength, Refresh [illegible], CVS Relief Roll-on, Vit D3, Retaine, [illegible] 1000mg, [illegible] Cream 0.05%, [illegible] DP Ag 0.05% and [illegible]. [illegible] at 3:35pm - The Administrator and Resident Care Director were made aware of the medications and stated they were aware of the resident keeping meds in her room.	A 052		

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A 052	Continued From page 13 at 3:38pm - The Administrator and Resident Care Director removed the unsecured medications from the resident's room. 2. Review of resident #9's 1823 revealed she required assistance with self-administration of medications. On at 11:18am - Resident #9 was observed sitting in her room with the seat of her 4 wheeled walker facing her. The walker contained a cup with three pills and a cup of water. The medication was left unsupervised for the resident to take. The resident stated the staff provides her meds, they do not state the name or dose, and they leave for her to take. She stated, "I have to trust what they provide because I'm legally ". Caregiver F immediately took responsibility for the medications left unsupervised in the resident's room and stated she knew she was wrong. Class III	A 052		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their	A 055		

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(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 055	Continued From page 14	A 055		

rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents.
(b) Both prescription and over-the-counter medications for residents must be centrally stored if:
1. The facility administers the medication;
2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request;
3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;
4. The resident fails to maintain the medication in a safe manner as described in this paragraph;
5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or
6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C.
(c) Centrally stored medications must be:
1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times;
2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked;
3. Accessible to staff responsible for filling

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 _____	06/21/2023

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PALM COTTAGES OF ROCKLEDGE	3821 SUNNYSIDE COURT ROCKLEDGE, FL 32955

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A 055	Continued From page 15 pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by:	A 055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 055	Continued From page 16 Based on observations, interview, and record review the facility failed to ensure 1 of 2 residents' medication was properly stored in a secure place that is out of sight of other residents (#8). Findings: In review of Resident #8 Physician Order Report dated . . . . . - . . . . . the resident may self-administer . (D3) and . . . . . dropperette. On . . . . . at 10:53am - Resident #8 was observed in her room and numerous unsecured medications were identified. 0n . . . . . at 3:35pm - The Administrator and Resident Care Director stated they were aware of the resident keeping meds in her room. On . . . . . at 3:38pm - The Administrator and Resident Care removed the authorized unsecured medications from the resident's room. The D3 and was returned as the doctor had submitted orders to self-administer. Class III	A 055		