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
	AL11968401	A. BUILDING: _____ B. WING _____	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
S&B KINGDOM CARE, LLC	53 RIVIERE LANE PALM COAST, FL 32164

(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 An abbreviated relicensure survey was conducted at S & B Kingdom Care on 06/06/2024. Deficiencies were identified at the time of the survey.	A 000		
A 032	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.	A 032		

AHCA Form 3020-0001

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

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A 032	Continued From page 1 The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure three of three personnel participated in two elopement drills per year. The findings include: Review of facility records showed that Employee A, Employee B, and the Administrator participated in an elopement drill on 01/24/2023. There were	A 032		

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A 032	Continued From page 2 elopement drills leading up to 01/24/2023 but none after this date were in the facility records. In an interview with the Administrator on 06/06/2024 at 11:19am she confirmed there were no more elopement drills to produce and she acknowledged the requirement to do two per year. Class III	A 032		
A 056	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 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	A 056		

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A 056	Continued From page 3 medication and any limitations must be specified; for example, "as needed for pain, 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 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	A 056		

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A 056	Continued From page 4 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 observation, record review, and interview, the facility failed to ensure as needed medications had set parameters when unlicensed staff provided assistance with self-administration of medications for 1 of 3 residents, and failed to ensure medication changes were promptly updated in the records of 1 of 3 residents. The findings include: 1. Review of the medication observation record (MOR) for Resident #2 showed she was prescribed Lorazepam .5mg every 6 hours as needed. There were no parameters for the Lorazepam. There were no set times written on the MOR and the signatures for when it was given did not have time entries. The as needed medication was being given every day, several times a day for the month of June 2024.	A 056		

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A 056	Continued From page 5 Signatures were from unlicensed med techs. Photographic evidence obtained. Observation of the bottle of Lorazepam on 06/06/2024 at 8:40am showed the medication was to be given every 6 hours. There was not any language on the label to indicate it was every 6 hours as needed. There was no alert placed on the label. In an interview with the Administrator on 06/06/2024 at 9:18am, she reviewed the as needed Lorazepam entry on the MOR and confirmed there were no parameters. After reviewing the label and the MOR, she called the physician's office to clarify if it was as needed, as the MOR stated, or just every 6 hours,the label stated. At 11:55am on 06/06/2024 she was observed calling again to clarify the Lorazepam order. The doctor's office was on speakerphone and confirmed the medication was as needed like the MOR said, not the label. 2. Review of the June 2024 MOR for Resident #3 showed she was prescribed Losartan 50mg once a day. Photographic evidence obtained. On 06/06/2024 at 9:02am an observation of the label on the medication bottle for Resident #3's Losartan showed it was a 100mg dose. There was no alert label on the bottle. The Administrator was asked at that time whether the order changed from 50 to 100mg. She called the hospice provider to inquire about when the order changed from 50 to 100mg. The order was produced and indicated the	A 056		

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A 056	Continued From page 6 Losartan changed from 50 to 100 mg on 02/14/2024. Photographic evidence obtained. In a second interview with the Administrator on 06/06/2024 at 11:51am the MOR from February 2024 was reviewed along with the order change in February 2024 from 50mg to 100mg. She explained created the MOR's each month. She confirmed the MOR and label were never updated to indicate the order change. Class III	A 056		
A 083	59A-36.011(5) FAC Training - First Aid and CPR (5) FIRST AID AND CARDIOPULMONARY RESUSCITATION (CPR). A staff member who has completed courses in First Aid and CPR and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current CPR certification that requires the student to demonstrate, in person, that he or she is able to perform CPR and which is issued by an instructor or training provider that is approved to provide CPR training by the American Red Cross, the American Heart Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R.	A 083		

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A 083	Continued From page 7 This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a staff member with current First Aid certification was present in the facility at all times for the care of the three residents of the facility. The findings include: Review of the facility schedule showed Employee A, Employee B, and the Administrator worked in direct care positions during a 24 hour period. Review of the records for Employee A, Employee B, and the Administrator showed they received they all CPR training which was valid through 2025. There was nothing in the record to show this training included First Aid. The records showed none of the employees were licensed nurses. In an interview with the Administrator on 06/06/2024, she was asked about the CPR training and whether it included First Aid. She confirmed on 06/06/2024 at 12:26 pm after calling the trainer that her course did not include First Aid. She confirmed the staff all needed First Aid training. Class III	A 083		
A 085	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of	A 085		

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A 085	Continued From page 8 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff obtained 2 hours of inservice training annually in food services for the 3 residents of the facility who receive meals from facility staff. The findings include: Record review of the Administrator's file showed she received food service education in 2020 which expired in January 2024. There was no education certificate in the record past the 2020 inservice date. During an interview with the Administrator on 06/06/2024 at 9:51am she confirmed the expired food service education from 2020 was the most recent she could provide. Class III	A 085		