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 _____	

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 _____ conducted Complaint inspection CCR#2012001723 at Palm Cottage of Rockledge Assisted Living Facility (ALF). The complaint was conducted in conjunction with Complaint Inspections CCR#2012004064 and 2012004153 and the biennial re-licensure survey. The Three Allegations in this complaint were substantiated. The ALF had deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or _____ services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms	A 008		

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 _____	

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 008	Continued From page 1 of a communicable _____ which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, phone number, and license number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state. (b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, October _____. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows: 1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment. a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion. b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider. c. Omitted information received verbally must be	A 008		

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 _____	

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 008	Continued From page 2	A 008		

documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.
2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the elements in Section 3. This requirement does not apply for residents receiving:
a. Extended congregate care (ECC) services in facilities holding an ECC license;
b. Services under community living support plans in facilities holding limited mental health licenses;
c. Medicaid assistive care services; and
d. Medicaid waiver services.
(c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.
(d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule.
(f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the

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 _____	

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 008	Continued From page 3 health assessment. A licensed health care provider may attach a order for residents who do not wish to be administered in the case of or (g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to obtain an accurate and completed medical examination report (1823) for 1 of 16 sampled residents (#5) that addressed all criteria necessary to determine admission to the Assisted Living Facility. Findings: Record review for Resident #5 revealed an 1823 that was dated with diagnosis of and stated she needed help with medications. Review of the 2012 Medication Observation Record revealed the staff was assisting with self-administration of medications. The 1823 did not accurately reflect the resident needs for medication assistance or	A 008		

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 _____	

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 008	Continued From page 4 administration. Interview with the administrator and the Director of Nursing on [redacted] at approximately 2:15 PM who stated the physician needed to update the 1823. It was further stated that the resident was able self administer his/her medications and the staff watched and charted. Class III	A 008		
A 010	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a [redacted] pressure [redacted] may be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health	A 010		

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 _____	

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 010	Continued From page 5	A 010		

agency or a nurse to provide care;
2. The condition is documented in the resident ' s record; and
3. If the resident ' s condition fails to improve within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility.
(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed;
2. Continued residency is agreeable to the resident and the facility;
3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility ' s license and total help with the activities of daily living; and
4. Documentation of the requirements of this paragraph is maintained in the resident ' s file.
(d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility.
(e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C.
(5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident ' s needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.

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 _____	

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 010	Continued From page 6 This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 16 sampled residents (#13) who was on hospice; had an interdisciplinary care plan developed and implemented by a licensed hospice in consultation with the facility Findings: Resident record review for resident #13 on : at approximately 2 PM revealed a health assessment dated that listed diagnoses of and chest pain. Another assessment dated indicated diagnosis of . The resident needed assistance with ADL's and medications. A doctor's order dated indicated Wuesthoff Brevard hospice patient, O2 at 3 litters via nasal cannula continuous. Another doctor's order dated not signed indicated : at 600 before out of bed (OOB) per hospice. Continued review including the hospice resident record revealed that the interdisciplinary plan that delineated the responsibilities of care to the resident by the facility and hospice was not available. The nursing supervisor stated at the time she would give hospice a call. At approximately 4 PM she stated that plan was not available. Class III	A 010		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident,	A 025		

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 _____	

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 025	Continued From page 7	A 025		

including the following:
(a) Monitor 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 individual.
(c) 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; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.
(e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on record review, observations and interview the facility failed to maintain a written record of significant changes, illnesses which resulted in hospital admissions and that the family, case manager and health care provider were notified for 4 of 16 sampled residents (#1,#2, #3 & #5), did not notify the health care provider when 1 of 16 residents continued to refuse medications (#10) and provide appropriate supervision to meet the needs for 2 of 16 sampled residents (#14 & #16), medications not

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 _____	

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 025	Continued From page 8 given per physician's order for 1 of 16 sampled residents (#7 & #8). Findings: 1. Record review for Resident #3 revealed a Resident health Assessment (1823) form that was dated [redacted] with diagnosis that included [redacted] and special precauti[redacted] Review of the Medication Observation Record (MOR) for [redacted] 2011 through 2012 revealed that the resident was in the hospital. Review of an incident report that was dated [redacted] at 4:10 AM noted the resident [redacted] out of bed which caused him to hit his head on the carpet leaving a scrape across his forehead as well as a small cut on top of his head and opening old [redacted] on his right hand. Hospital admission was checked yes. Further review revealed there was no documentation to confirm what had transpired in [redacted] causing the resident to be admitted into the hospital and there was no documentation to confirm the date that he returned to the facility. Further record review revealed there was no documentation in the record to indicate when the resident returned to the facility after the hospital admission on [redacted] nor was there documentation that the health care provider and the family members were aware of the hospital admissions. 2. Record review for Resident #10 revealed an 1823 dated [redacted] with diagnoses that included [redacted] and [redacted] There were special precautions for [redacted] Also, the resident required supervision with the self administration of medications:	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 _____	

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 025	Continued From page 9	A 025		

Review of a lab report dated revealed the resident's hemoglobin was 10.4 and the lab indicated that it was low. The resident's health assessment form (1823) dated noted Poly Iron twice daily.
The MOR for from through the resident refused the Poly Iron, however the front of the MOR was marked as given. The MOR from 6/1 through noted that the resident refused the Poly Iron the front of the MOR for was marked as given.
Review of the MOR revealed that on 7/3 at 9 PM, 7/5 at 9 PM and 7/9 at 9 AM and 9 PM the resident refused the Poly Iron. The front of the MOR noted that it was given on those days and there was an initial with a circle on .
There was no documentation to confirm that the health care provider was contacted to inform him that the resident was refusing to take the medications that was prescribed because she had a low hemoglobin, in order to obtain further instructions. Review of the order requisition form dated revealed that the resident had a diagnoses of Iron deficiency unspecified electronically signed by the PA-C.
The DON stated she thought that the staff had notified the health care provider that the resident was refusing the Poly Iron. The staff searched for the documentation and did not provide any evidence the health care provider was aware that the resident was refusing the Poly Iron.
3. Resident #14 was identified as being on hospice. Health assessment dated that listed diagnoses of back pain, debilitation, severe and . The resident was on hospice. Shift note dated 11-7 shift cottage 3820 "Left out of cottage side door again only knew he was gone because he was knocking on the back door. Can we have an

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 _____	

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 025	Continued From page 10	A 025		

alarm on the back door, like it is on the front door, so we know when he is leaving out, I mean God forbid if he would have went on towards the entrance and left, we would not have known until we were doing rounds again. Tried to leave 2 more times".
4. Resident # 16 had a health assessments 11/1 | 11/2 | Alzhei fibs, HTN, | term memory deficit | low vision at night. According to the assessment the resident was independent with transfers, needed supervision with bathing, dressing, grooming, | and eating.
The observation record log indicated that on | left cottage and came over to club house. Resident loves to come over and sit and watch club house". On 4/1; | got out this AM to go to mail cottage to visit with others".
The shift communications notes indicated that on 4/__ : PM to 11PM- [name] need to be watched at all times because she was trying to walk down the street by herself this happen twice and one day
4/23-11-7 shift wandering out more often
4/__ -3 shift Please watch [name] for wandering. Will schedule assessment Monday for dementia __ 11shift [name] needs extra attention because she just been walking down the street
No date and time - [name] still confused, ... tried to walk down the street
5/9 was annoying to other resident who watched TV
5/ | not indicated fell | porch
5/ ... 11- 7 shift behavior getting worst -more noise and aggravating residents
5/2. 11shift decided to walk to office to go to sleep I walked with her and brought her back
5/. 11 shift Resident wandered out twice
6/2; up around 2 AM, fully dressed and

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 _____	

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 025	Continued From page 11	A 025		

ready to go. Refused to go back to bed. We had her sit and watched TV until around 4 PM
3:30 AM - HA went to cottage from Coconut cottage to find that : not in bed/cottage. She was found in the office where she was taken to Coconut with HA, so she could keep an eye on her.
Observations of the resident on said date at approximately 11AM noted she sat in the common area on cottage 3820. She was , thought she knew me, was happy I came over and was I starting to work there.
7-3, 3-11 "Resident in walking out the side door, late at night, looking for his care. Resident would not go back in the cottage had to take resident to the locked unit".
7-3, 3-11 Resident sampled #6 " again he was found outside, going to airport".
11-7 shift house # 3030 went to resident's "I think I scared him, he tried going out the back/side door again in the rain, no shoes, and cussing". That cottage is going to need a person stationed in here if he keeps on wandering in other peoples' and leaving. He is hard to re-direct".
: 7-3 Sylvester (Cottage #3806)
-went for a walk today, walked but almost to Barnes. A police officer saw her and brought her back. The family called they were not upset".
Facility shift notes indicated that on:
-Cottage 3820 stated she pushed pendant 3 or 4 times, starting about 2 PM. The only call that came across board was at 5 PM. She wanted someone to put her juice on the table
11-7 "up pager not working properly, 30 pager not working".
"sup pager and had to let me know by phone".
: 11-7 shift "sup pager is still not working"
The facility's elopement risk policy indicated the

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 _____	

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 025	Continued From page 12	A 025		

"Resident Care director shall monitor that each resident is screened for potential /wandering prior to admission, readmission and on quarterly basis". The policy indicated the "assisted living elopement risk from "would be used. There would be 7 areas assessed and a scored 12 or more, the resident would be at risk of elopement. The policy also indicated that "residents who are at risk for elopement will have identification on their persons at all times".

Continued individual resident record review for residents # 14 and 16 revealed no evidence to confirm that per facility policies an elopement assessment had been done on these 2 residents who exhibited a wandering and exit seeking behavior to ensure they received the supervision they needed to ensure they remained safe.

The nursing supervisor and administrator stated at approximately 2 PM on [redacted] that the assessment had not been done, although the policy said otherwise.

5. Record review for Resident #5 revealed an 1823 that was dated [redacted] with diagnosis of [redacted] and stated she was a [redacted] risk.

Review of facility note in a book revealed on [redacted] the resident [redacted] and went to the hospital at 9:35 pm. There was no documentation to review to indicate the physician was notified and no note of return. There were pages torn out of facility note book.

Interview with the administrator and the Director of Nursing on [redacted] at approximately 4:30 PM who stated the staff wrote notes in a notebook. They had no comment regarding pages that were

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 _____	

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 025	Continued From page 13 torn out of the book. 6. Review of indicdent report for resident #1 dated : revealed the resident was found with a lacerations above his left eye, on both elbows, and the right thumb. The resident was sent out to the hospital. There was nop documentation when the resident returned to the facility and if the legal was notified on the resident's ... and subsequently being sent to the hospital. 7. Review of an incident report dated for resident #2 revealed the resident was found after tripping and falling in her ..... She landed on her left hip and complained of pain. The resident was sent out to the hospital. There was no notes or discharge notes in regards to the resident being sent out to the hospital or notifying her legal guardian. Conducted phone interview on at approximately 11:00 am, with the direct-care staff, who works on the afternoon shift from 3:00pm-11:00pm. She worked the evening of the incident with resident #2 on ..... According to the direct care staff, the ... happened around 10:30 pm and she did witness the resident falling over her nightstand and landing on her left hip. The direct care staff called her supervisor and she remembers three supervisors showing up. The direct care staff reported that one of the supervisors called resident #2's son and then resident #2 was sent to hospital. On ..... at approximately 2:55pm, conducted interview with staff supervisor. The supervisor stated "I don't have to answer why we did not have any notes in their medical books about the	A 025		

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 _____	

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 025	Continued From page 14 incidents." 8. Resident record review on at approximately 4:15PM for resident #7 revealed an Assisted Living Facility Health assessment form (1823) dated that stated a diagnosis of , Agitation, D Deficiency, B Deficiency, history of open surgery, left knee replacement, right hip replacement. The resident needed assistance with self- administration of medication. Review of physician order for resident #7 dated 20 milligrams (mg) Tablet revealed to hold if is less than 110 and call physician. Record review of the 2012 medication observation record (MOR) for #7 revealed that 20 milligram (mg) was not given on , 2012 at 9AM. The MOR was not initialed that the medication was given. There was no notation on the back of the MOR to indicate why the medication was not given. 9. Resident record review on at approximately 4:30PM for resident #8 revealed an Assisted Living Facility Health Assessment form (1823) dated that stated diagnosis of and The resident needed assistance with self-administration of medications. Review of physician order for resident #8 dated :012 50 milligram tablet, one tablet at 9AM and 9PM. Hold if is less than 100. Record review of the 2012 and 2012 medication observation record or resident #8	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 _____	

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 025	Continued From page 15 revealed that [redacted] 50 milligram (mg) tablet was not signed for as given on the following dates and times: [redacted] 25 & 28, 2012 at 9 PM and [redacted] 012 at AM and [redacted] 012 at 9 PM. Interview with the Director of Resident Care on [redacted] at approximately 2 PM stated If the MOR is not signed for a given date the medication was not given. Class II	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the	A 030		

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 _____	

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 030	Continued From page 16	A 030		

Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s alcohol tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.

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 _____	

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 030	Continued From page 17	A 030		

(h) Pursuant to Section 429.41, F.S., the use of physical . . . . . shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical . . . . . .

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from . . . . . and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve

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 _____	

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 030	Continued From page 18	A 030		

the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a [redacted] his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [redacted] the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff

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 _____	

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 030	Continued From page 19 of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the residents of the facility lived in a safe and decent living environment Findings: During the tour of the facility on at approximately 11:50 PM revealed that there was no staff member in the cottage where the office was located. The surveyors entered walked around and called out to see if someone would answer. In approximately 3 minutes a staff arrived and stated that she was the manager on Duty. She stated that there were 8 cottages and during the night shift 11 PM-7AM four cottages 3830-11 residents present and 3831-10 residents present one staff was responsible for the supervision of the Residents in both. 3820-9 residents present and 3826-12 resident's present -one staff was responsible for the supervision of the Residents in both. residents present and 3806 - 11 residents present one staff was responsible for the supervision of the Residents in both. She stated Cottages 3816 and 3810 were the secured units and there was one staff in each. She stated that the staff would remain in a cottage for 1 hour and then go to the	A 030		

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 _____	

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 030	Continued From page 20	A 030		

other cottage. If a resident needed something they could push their pendant for assistance and the staff would leave the cottage to see what was needed. She stated this was the only shift that did not have staff in each one. Upon entering several cottages where residents were located the doors were unlocked and no staff was inside. Anyone could have walked into the cottages and no one would have known.

Interviews with staff revealed that previously there was a staff in each cottage.
Further interviews revealed that there were raccoons on the property. The staff would be afraid to leave out of the cottage to go to the other cottage because of the raccoons.

During the tour of the facility a raccoon was observed walking, Observations revealed that there were raccoon walking around the property.

During interview with the administrator on at approximately 1 PM who confirmed that a staff was feeding the raccoons. When she found out she told her that she had to stop. She further stated that there was also a resident who resided in the back who would feed the raccoons because that's what she did when she lived on the farm. They informed the resident that she could not feed the raccoons. The administrator further stated that prior to the new owner, they use to have a staff in each cottage and the owners thought that the staff were sleeping during the night instead of watching the resident's and thought that if the staff had to go from cottage to cottage that would keep them awake.

Review of the facility pamphlet used as advertisement revealed that it noted "24/7 Care Giving Staff".

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 _____	

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 030	Continued From page 21 On [redacted] at approximately 11:04 pm, two raccons were observed walking across the back yard of cottage 3811. Also, the front door was unlocked and no night staff was present. A tour of the facility was conducted without night staff knowing. there were eleven residents asleep at the time. At approximately 11:30pm, observation of cottage no. 3806 revealed that the front door was unlocked, with ten residents asleep. While touring the facility, met with the night staff who stated that he covers both facilities. Stated he has radio contact with the night supervisor if there are any issues that arise and every two hrs. the supervisor makes rounds at each facility. Asked the night staff how much time the supervisor spends in each facility. The night staff said that he was not sure of the amount of time because it depends on what is going on. Class II	A 030		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider ' s name, the resident ' s name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility shall maintain a daily medication observation record (MOR) for each resident who	A 054		

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 _____	

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 054	Continued From page 22 receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure staff maintained a daily Medication Observation Records (MORs) for 1 of 16 sampled residents (#5), who received assistance with self-administration of medications. Findings: Review of the Assisted Living Facility health assessment form for resident #5 dated revealed the resident needed help with medications. Review of the MORs revealed: (for pain) 300 milligrams (mg) 3 times a day. The medication was not charted as given; no initials were in the boxes at 7 AM, 3 PM and 11 PM on and at 7 AM on and	A 054		

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 _____	

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 054	Continued From page 23 The following medications were not charted as given at 8 AM 6/ 6/30 mg daily Levothyroxine 0.075 Plavix mg daily Lisinopril blood mg twice a day was not charted as given at 8 AM and 11 PM on 6/ 6/ was not charted as given at 8 AM on 6/ 6/30 nausea) mg every 8 hours and Sloniacin 5 mg every 8 hour was not charted as given at 7 AM, 11:30 AM and 4:30 PM on 6/ 6/2 at 7 AM and 11:30 AM on 6/ 6/30 patch (for pain) 50 micrograms/hour one patch every 72 hours was not charted as given on 6/5, 6/8, 6/ 6/2 was no documentation on the MOR to indicate the reason the medications were not given. Interview with the Director of Nursing on 7/1 at approximately 2:15 PM who stated the resident was independent with medication and self medicates and staff watches and charts. Class III	A 054		
A 056	58A-5.0185(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) No prescription drug shall be kept or administered by the facility, including assistance with self-administration of medication, unless it is 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	A 056		

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 _____	

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 056	Continued From page 24	A 056		

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. Identification of each medicinal drug product in the container.
(b) Except with respect to the use of pill organizers as described in subsection (2), no person 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 shall 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 shall 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, shall be noted in the medication record, or a revised label shall be obtained from the pharmacist.
(d) Any change in directions for use of a medication for which the facility is providing assistance with self-administration or administering medication must be accompanied by a written medication order issued and signed by the resident ' s health care provider, or a faxed copy of such order. The new directions shall promptly be recorded in the resident ' s medication observation record. The facility may then place an " alert " label on the medication container which directs staff to examine the revised directions for use in the MOR, or obtain a revised label from the pharmacist.
(e) A nurse may take a medication order by

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 _____	

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 056	Continued From page 25	A 056		

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 copy of a signed order is acceptable.
(f) The facility shall 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 64F-12.006, 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 shall also 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 shall 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 shall provide the resident with a written prescription, or a fax copy of such order.

This Statute or Rule is not met as evidenced by:
Based on medication review and interview the facility did not make every reasonable effort to ensure that prescriptions were filled or refilled in a timely manner for 5 of 16 sampled residents (#3,

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 _____	

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 056	Continued From page 26	A 056		

#6, #9, #10 & #13) who received assistance with self-administration of medications (#3) which resulted in the staff having to use another resident's prescribed medications for a resident that it was not prescribed for (#10).

Findings:

1. Record review for Resident #3 revealed a Resident health Assessment (1823) form that was dated [redacted] with diagnosis that included [redacted] and had special precautions for [redacted]. The resident required assistance with the self administration of his medications.
Review of the Medication Observation Record (MOR) revealed that the resident's medication was marked as not given on the back because it was not available as follows:
[redacted] MOR
3/2, 3/3 and 3/4/ the [redacted] 100 mg was on order and not given.
[redacted] MOR
[redacted] 80 mg from 4-11 through 4-17 was on order not given. Tamsuolosin [redacted] 0.4 mg was not given on [redacted] and [redacted] on order not given.
[redacted] MOR
The back of the [redacted] MOR noted on the following dates [redacted] the [redacted] 160-25 mg, [redacted] CL/ER was not given waiting on order.
After the [redacted] dates were [redacted] through [redacted] the [redacted] 80 mg was not given because it was on order.
[redacted] (sic) was not given becuause it was on order. On [redacted] was not given because it was on order, [redacted] {sic} was not given because it was on order.
[redacted] was not given because it was on order.

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 _____	

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 056	Continued From page 27 : 9AM and 5 PM was not given because it was on order and was not given because it was on order MOR 6/4, 6/5, 6/6, 6/9 through 1 daily was not given because it was on order. 6/5 through 6/9 5 mg 1 daily was not given because it was on order. 6/8, 6/9, and 2 times daily was not given because it was on order. 6/7 and 6/8 was not give because it was on order MOR 7/1 through 7/8 and through 2 times daily was not given because it was on order. , 19 5 mg 1 daily was not given because it was on order. MOR 9/1, 9/3, 9/4, 5 mg 2 times daily was not given because it was on order. MOR through 80 mg 1 daily was not given because it was on order. through 40 mg 1 daily was not given because it was on order. MOR through 80 mg 1 daily was not given because it was on order. 2. Record review for Resident #10 revealed an 1823 that was dated with diagnosis that included and nt-Special precauti The resident required supervision with the self administration of her medications. Review of the Medication Observation Record	A 056		

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 _____	

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 056	Continued From page 28 (MOR) for ... revealed that the resident was to have ... 0.5 mg 1 at bed time, The MOR noted on the back that on 7/1, 7/3, 7/5 and 7/6 the medication was not give and was order. Review of the Controlled Substance record for ... revealed that the last day that the ... was given and available was on ... and the count was 0. Review of the current Controlled substance record revealed that it was started on ... Further review of the front of the MOR revealed that the medications were marked as given on 7/2 through 7/9 although the back noted on some days the medication was not given. Review of a Fax that was dated ... to the health care provider that noted "may we please have a refill script for the following: 0.5 1 at bedtime. The prescription was dated ... The medication ran out on ... and the refill was not requested until ... The Staff that was responsible for the ordering of the medication stated because the medication was a ... it could not be called into the pharmacy, it required an actual physician's prescription and sometimes it took a couple of days for the physician to provide the prescription to the facility. Review of the medication delivery record revealed that the medication did not arrive to the facility until ... Interview with a staff present on ... at approximately 1 PM who had signed the MOR on ... as given (even though there was no medication available at the facility since ... for resident #10, she stated that she did give the resident her medication. She was asked at the time to explain how the medication was given if it was not available. She stated she would check	A 056		

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 _____	

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 056	Continued From page 29 and determine when the medication arrived to the facility. At approximately 1:30 PM the staff returned and stated that she took medication from another resident that used the same medication to give to the resident and when resident #10 medication arrived she had planned on replacing it. She provided the bottle from where she took the medication from. The bottle was for another resident. This medication was not included in the other resident's count and she stated it was probably a bottle of medication that the other resident brought from home. The prescription label date on the bottle was , there were (4) half pills in the bottle. She stated that she took (2) half's and gave to the resident. The staff who was not a pharmacist or nurse, used her judgment to take a prescription medication from the bottle of another resident that was possibly brought from home, not knowing that the medications that was in the bottle was actually what was on the label. 3. Resident #13 had a health assessment dated that listed diagnoses of and chest pain. Another assessment dated indicated diagnosis of and she needed assistance with ADL's and medications. The 2012 Medication Observation Record (MOR) listed 74 mcg daily and had staff initials circled on and . The back page of the MOR indicated the was "not available" those 2 days. The 2012 MOR listed 2 mg daily and had staff initials circled from 6/1 to . The back page of the MOR indicated the medication was "on order" and not given on 6/1, 6/4 and . The MOR also listed 20 mg daily and was blank every morning. There	A 056		

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 _____	

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 056	Continued From page 30 were no notations as to why the MOR was blank and the medication not given. 4. Resident #9 had a health assessment report dated [redacted] that indicated diagnoses of [redacted] with [redacted] body [redacted], bi- polar [redacted] and [redacted] She required assistance with self-administration of medications. She was independent with eating, needed assistance with ambulation, bathing, dressing, toileting, and transfers; needed supervision with [redacted]. Order dated [redacted] indicated [redacted] 75 mg every morning and 275 mg every evening. The MOR [redacted] 2012 listed [redacted] 50 mg, [redacted] 12/5 mg at bedtime and Singulair 10 mg in the evening and had staff initials circled, indicating the medications were not given from [redacted] to [redacted] 250 mg at bedtime was blank on [redacted]. A physician visit report dated [redacted] indicated the resident "was about the same, irritable/negative". A hand written notation on the left bottom side of the page indicated "I prescribe all her psych meds, please". A hand written notation on the right bottom side of page indicated "Please clarify for me why patient did not receive [redacted] for 9 days in [redacted]. The MOR dated [redacted] 2012 listed Singulair10 mg in the evening and had staff initials circled, indicating the medication was not given from 4/1 to [redacted]. The back page of the MOR indicated that Singulair was "out" on [redacted] 50 mg at bedtime had staff initials circled, indicating the medication was not given from 4/1to 4/9. The back page of the MOR indicated [redacted] was "on order" from 4/1 to [redacted] 12/5 mg at bedtime had staff initials from 4/1 to [redacted]. There were no notations as to why the medication was not given or available. [redacted] 75 mg every	A 056		

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 _____	

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 056	Continued From page 31	A 056		

morning had an arrow on 4/1 and 4/2 and then had staff initials circled from 4/6 to [illegible] | 275 mg had staff initials circled from [illegible] to [illegible]. The back page of the MOR indicated that on [illegible] | 75 mg was "on order, given 200 mg out of 275".
Prescription dated [illegible] indicated Singulair 10 mg every evening, [illegible] | 20 mg give along with 3 tabs of 75 mg to equal 275 mg at bedtime, [illegible] | 25 mg every morning and 3 to be given with 20 mg, [illegible] 50 mg
A letter from the nursing supervisor to administrator dated [illegible]. The letter indicated there was a delay obtaining a health assessment from the resident's daughter and from hospice. The writer indicated the facility attempted to help daughter in getting medications for the resident. "There were problems and the resident went without 9 doses of 2 of her medications". The daughter came today [illegible] and complained the resident was out of meds again and missed some doses. "The medication in question [illegible] had not run out, the resident missed 2 doses due to the fact that the med tech was not aware that, as of last week, a generic is now available for [illegible] and she did not recognize the name and thought there was no [illegible] available".
A letter dated [illegible] from the administrator to the resident's daughter indicated the resident did not get [illegible] for 2 days because the staff did not recognize the generic name of the medication. The staff did not follow procedure to call the supervisor when they cannot find a medication.
The Medication list dated [illegible] and signed by the healthcare provider listed [illegible] | 200 mg one at bedtime give along with 3 tablets of 25 mg to equal 275 mg at bedtime. And [illegible] | 25 mg give 3 tablets every AM (to equal 75mg) and 3

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 _____	

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 056	Continued From page 32	A 056		

tablets every PM (to equal 75mg) PM dose to be given with 200 mg. . . . . 50 mg one tablet at bedtime.
Fax not dated indicated "resident need refills on her . . 30 mg plz advise", signed by the facility's medication QA.
A fax dated . . . requested a refill for . . . . The healthcare provider replies to request medication from psych doctor, as med was written by him.
The administrator stated at approximately 4 PM that she had created a position of Quality Assurance Medication Tech, to ensure that medications were always refilled timely and accurate. She was very disappointed to see that it had not worked as she expected.
Review of the Quality Assurance medication Tech job description revealed he job duties entailed responsibility for the review of all medications as it pertained to ordering refills, storage, carts, MORs, and training of resident care technicians on supervision of mediations. Item # 4 of the job description indicated notify by fax or phone to preferred pharmacy, call to families who don't use that pharmacy to remind refills were due. Notification for refills to families and mail order should be done in a timely manner- with a minimum of 7 days out due to family/mail order coordination. The qualifications for the job were 4 hour assistance with medication training, First Aid and preferably a Certified Nursing Assistant (CNA).
A note posted in the MOR binder located in each house indicated it was "All RCA's were responsible for monitoring medications!! When medications are low, the peel off label may be placed on the reorder form "If no peel off label is available, you must write it on the same form by hand. This must be available to [NAME] on daily basis". The AM medication date Cottage indicated "if any medication is out tell a supervisor or write

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 _____	

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 056	Continued From page 33 it down and give it to the QA of meds". The QA of medications stated at approximately 12:30 PM that sometimes she had problems obtaining the medication refill orders from some of the physicians. 5. Interview with staff revealed that an unqualified staff was not following doctor's orders. Reviewed of Resident #6 ' s Medication Order Record (MOR ' s) revealed that resident #6 receives the following medications: 1. Table P.O. twice daily 2. 24mcg P.O. twice daily 3. 15mg P.O. twice daily 4. 600mg P.O HS 5. 60mg P.O. HS 6. 50mg three times daily On 2012, all PM medications were not administered because the medications were on order according to the nurse's medication notes. However, the assigned Med Tech staff recorded and signed on the MOR's that the medications were given to resident #6. On at approximately 3:35pm, an interview with the Director of Nursing (DON) revealed that the Med Tech's are supposed to tell a supervisor or write down what medication is out and then give it to QA of medications. When told about the with resident #6's PM medications for 2012, the DON stated: "This should not have happened. We have an agreement with a local pharmacy. When we run out of any medications, we call the pharmacy and pick up the medications." Class II	A 056		
A 077	58A-5.019(1) FAC Staffing Standards - Administrators	A 077		

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 _____	

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 077	Continued From page 34 Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter. (a) The administrators shall: 1. Be at least 2. If employed on or after 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after 1995, must have a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and 4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must: 1. Be at least , and 2. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA	A 077		

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 _____	

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 077	Continued From page 35 Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the administrator failed to provide oversight of operations and provision of adequate care to the residents and did not ensure: 1. appropriate supervision was provided to meet the needs of 2 of 16 sampled residents (#14 & #16), 2. Physician's order were followed for 2 of 16 sampled residents (#7 & #8), 3. The residents lived in a safe, decent environment, 4. medications were refilled in a timely manner for 5 of 16 sampled residents (#3, #6, #9, #10 and #13), 5. licensed staff to provided nursing services to 4 of 16 sampled residents (#7, #8, #12, #13), 6. Obtained a Limited Nursing Service license before providing nursing services to 2 of 16 sampled residents (#12 & 13) and 7. Residents at risk of elopement (AR) had required identification on their person (#4, AR#1, AR#2, AR#3, AR#4, and #6.) Findings: Resident record review, observations and interviews revealed: 1. Appropriate supervision was not provided to meet the needs of 2 of 16 sampled residents,	A 077		

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 _____	

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 077	Continued From page 36 who were (#14 & #16) who were exit seeking and wandering. 2. Physician's order were not followed for 2 of 16 sampled residents (#7 & #8), who had medications with parameters. 3. The residents failed to live in a safe, decent living environment. Cottage doors were unlocked on the night shift, at 11 PM to 7 AM, and no staff was supervising the residents. Staff would cover 2 cottages on the night shift and make rounds every 1-2 hours, leaving one cottage unattended. Staff and a resident were feeding raccoons that were observed on the property. 4. Medications were not refilled in a timely manner for 5 of 16 sampled residents (#3, #6, #9, #10 and #13). 5. Unlicensed staff provided nursing services to 4 of 16 sampled residents (#7, #8, #12 & # 13). Residents #7 and #8 had medications with parameters administered, #12 had a leg brace applied and removed, resident #13 had administered. 6. Limited Nursing Service license was not obtained before providing nursing services to 2 of 16 sampled residents (#12 & 13). Resident #12 had a leg brace applied and removed and Resident #13 had administered by unlicensed staff. 7. Residents who were at risk of elopement (AR) did not have required identification on their person. Residents were identified as AR#4, AR#1, AR#2, AR#3, AR#4, and #6. Class II	A 077		

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 _____	

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 078	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable [redacted] including [redacted]. Freedom from [redacted] must be documented on an annual basis. A person with a positive [redacted] test must submit a health care provider ' s statement that the person does not constitute a risk of communicating [redacted]. Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable [redacted] he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C. (d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall	A 078		

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 _____	

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 078	Continued From page 38 specifically describe the services the staffing agency or contractor will be providing to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility shall: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and 2. Maintain time sheets for all staff. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure all staff were assigned duties consistent with his/her level of education, training, preparation and experience and allowed non licensed personnel to performed duties that required nursing licensure for 2 of 16 sampled residents (#7 #8, #12, #13 & #16). Findings: During the facility tour at approximately 10 AM a staff stated that they (unlicensed staff) assisted resident #13 with the 1. Resident #13 had a health assessment dated that listed diagnoses of and chest pain. Another assessment dated indicated diagnosis of . She needed assistance with ADL's and medications. Doctor's order dated indicated Wuesthoff Brevard hospice patient, O2 3 litters via nasal cannula continuous. Doctor's order dated not signed by MD, indicated at 60 before out of bed (OOB) per hospice. The MOR listed 50 mg twice daily, hold if SBP (first number) was less than 100 or rate less than 50, started . The was taken twice daily from 4/1 to . She	A 078		

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 _____	

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 078	Continued From page 39	A 078		

returned on [redacted] and the order for the [redacted] was changed. Continued observations of the MOR revealed the staff initials that indicated the [redacted] results were not nurses. The back page of the MOR had their staff initial and signature and none of the staff identified themselves as licensed staff /nurses. The [redacted] 2012 listed [redacted] 50 mg twice daily, hold if SBP [redacted] (first number) [redacted] was less than 100 or [redacted] rate less than 50. The [redacted] was taken twice daily from 5/1 to [redacted] when she went to the hospital and the order was changed. Continued observations of the MOR revealed the staff initials that indicated the [redacted] results were not nurses. The back page of the MOR had their staff initial and signature and none of the staff identified themselves as licensed staff /nurses. The [redacted] 2012 MOR listed [redacted] check daily and was done twice daily from 6/1 to [redacted] Continued observations of the MOR revealed the staff initials that indicated the [redacted] results were not nurses. The back page of the MOR had their staff initial and signature and none of the staff identified themselves as licensed staff /nurses.

The staff stated that they take the resident's [redacted] and then call hospice for further instructions as to whether or not to give the [redacted] medication.

Observations of the resident in her [redacted] at approximately 3 PM revealed that the hospice caregiver and case manager were present. Observations of the [redacted] concentrator revealed it was at 2 liters per minute. The hospice caregiver staff stated that the [redacted] concentrator was set at 2 liters per minutes. The administrator stated at approximately 4 PM that hospice will be contacted regarding the

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 _____	

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 078	Continued From page 40 2. Resident # 16 had a health assessments [redacted] and [redacted] dated that indicated [redacted] A fibs, [redacted] short term memory [redacted] and low vision at night. According to the assessment she was independent with transfers, needed supervision with bathing, dressing, [redacted] toileting, and eating. Shift note dated [redacted] indicated she returned at 6 PM, after visiting with family. Medications were brought back the "supervisor put them in the bottle". 3. Resident #12 had a health assessment (1823) dated [redacted] with diagnoses of elevated lipids, [redacted] type 2, [redacted] and [redacted]. The resident was on hospice and was not interviewable. Observation on [redacted] at approximately 9:45 AM revealed the resident had a left leg brace on. Interview with the unlicensed staff at that time who stated she applied and removed the leg brace. Interview with the administrator and the Director of Nursing on said date at approximately 4 PM who were not aware the unlicensed staff were applying and removing the brace. 4. Resident record review on [redacted] at approximately 4:15PM for resident #7 revealed an Assisted Living Facility Health assessment form (1823) dated [redacted] that stated a diagnosis of [redacted], Agitation, [redacted] D Deficiency, [redacted] B Deficiency, [redacted], history of open [redacted]: surgery, left knee replacement and right hip replacement. The resident needed assistance with self- administration of medication. Review of the physician order dated [redacted] 20 milligrams (mg) tablet hold if	A 078		

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 _____	

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 078	Continued From page 41 of less than 110 and call physician. Review of the 2012 Medication Observation Record revealed the resident was given 20 milligrams (mg) on by an unlicensed staff member. 5. Resident record review on at approximately 4:30PM for resident #8 revealed an Assisted Living Facility Health Assessment form (1823) dated that stated diagnosis of and The resident needed assistance with self-administration of medications. Review of the physician order for resident #8 dated 012 50 milligram tablet, one tablet at 9AM and 9PM. Hold if is less than 100. Record review of the 2012 Medication Observation Record revealed resident received Metopolol (for 50 milligrams (mg) tablet given at 9AM and 9PM on 12-9AM on by an Unlicensed staff. During iInterview with the administrator on at approximately 4 PM revealed she was not aware that unlicensed staff could not give medication requiring a judgment regarding the administration of medication. Class III	A 078		
A 162	58A-5.024(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records shall be maintained on the premises and include:	A 162		

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 _____	

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 162	Continued From page 42	A 162		

(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, responsible party, or other person the resident would like to have notified in case of an emergency, and relationship to resident; and
9. Name, address, and phone number of health care provider, and case manager if applicable.
(b) A copy of the medical examination described in Rule 58A-5.0181, F.A.C.
(c) Any health care provider ' s 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) A signed statement from a resident refusing a therapeutic diet pursuant to Rule 58A-5.020, F.A.C.
(e) The resident record described in paragraph 58A-5.0182(1)(e), F.A.C.
(f) A weight record which is initiated on admission. Information may be taken from the resident ' s health assessment. Residents receiving assistance with the activities of daily living shall have their weight recorded semi-annually.
(g) For facilities which 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.

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 _____	

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 162	Continued From page 43	A 162		

(h) For facilities which manage a pill organizer, assist with self-administration of medications or administer medications for a resident, 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, or 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 under Section 429.27, F.S.
(k) For any facility which 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 under Section 429.27, F.S.
(l) A copy of Alternate Care Certification for Form, CF-ES 1006, 1998, if the resident is an recipient. The absence of this form shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services.
(m) Documentation of the appointment of a health care surrogate, 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 under Rule 58A-5.0181, F.A.C.
(o) For apartments, duplexes, quadruplexes, or single family homes that are designated for independent living but which are licensed as assisted living facilities solely for the purpose of delivering personal services to residents in their

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 _____	

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 162	Continued From page 44	A 162		

homes, when and if such services are needed, record keeping on residents who may receive meals but who do not receive any personal, limited nursing, or extended congregate care service shall be limited to the following:
1. A log listing the names of residents participating in this arrangement;
2. The resident demographic data required under this subsection;
3. The medical examination 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.
(p) Except for resident contracts which must be retained for 5 years, all resident records shall 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 shall be provided a copy of their resident records upon departure from the facility.
(q) Additional resident records requirements for 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 observation, record review and interview the facility failed to ensure health care provider's orders for nursing services were obtained for 1 of 16 sampled residents (#12).

Findings:

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 _____	

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 162	Continued From page 45 Tour of the facility on [redacted] at approximately 9:45 AM revealed resident #12 was wearing a leg brace. Interview with the unlicensed staff on said date at the time stated they put the leg brace on the resident and removed the leg brace. Record review revealed an 1823 that was dated [redacted] with diagnosis of elevated lipids, [redacted] type 2, and [redacted]. There was no documentation to review to indicate the physician had written an order to apply and remove the leg brace. Interview with the administrator and the Director of Nursing on said date at approximately 4 PM, who stated they could not locate the order. Class III	A 162		
AZ803	408.804, F.S. License Required; Display (1) It is unlawful to provide services that require licensure, or operate or maintain a provider that offers or provides services that require licensure, without first obtaining from the agency a license authorizing the provision of such services or the operation or maintenance of such provider. (2) A license must be displayed in a conspicuous place readily visible to clients who enter at the address that appears on the license and is valid only in the hands of the licensee to whom it is issued and may not be sold, assigned, or otherwise transferred, voluntarily or involuntarily. The license is valid only for the licensee, provider, and location for which the license is issued.	AZ803		

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 _____	

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
AZ803	Continued From page 46	AZ803		

This Statute or Rule is not met as evidenced by:
Based on observation and interview the facility failed to obtain a license for Limited Nursing Services before providing the service for 2 of 16 sampled residents (#12 and #13).

Findings:

1. Tour of the facility on 7/1(: approximately 9:45 AM revealed resident #12 was wearing a leg brace. Interview with the unlicensed staff on said date during the inspection who stated they put the leg brace on the resident and removed the leg brace.

Record review revealed an 1823 that was dated 3/1 diagnosis of elevated lipids, hypertension, 2, and dementia.

of the facility's posted license revealed the Assisted Living Facility Standard license expired on 7/2

During the facility tour at approximately 10 AM a staff stated that they (unlicensed staff) assisted resident #13 with the oxygen. #13 had a health assessment dated 03/16 listed diagnoses of HTN atypical pain. Another assessment dated 12/1 diagnosis of dehydration. needed assistance with ADL's and medications. Doctor's order dated Wuesthoff Brevard hospice patient, O2 (oxygen) litters via nasal cannula continuous.

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 _____	

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
AZ803	Continued From page 47 Interview with the administrator and Director of Nursing on said date at approximately 4 PM who stated they were unaware the staff was assisting the resident with the leg brace and the and needed a nurse to provide the Limited Nursing Service. Class III	AZ803		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Palm Cottages Of Rockledge
3821 Sunnyside Court
Rockledge, FL 32955

Dear Administrator:

Re: CCR #2012001723

This letter reports the findings of a state licensure survey that was conducted on , 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **, 2012,** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998