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 |
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| A 000 | Initial Comments<br><br>An Assisted Living Facility with Limited Nursing Services (LNS) standard biennial licensure survey was conducted on October . The Place at Vero Beach had licensure deficiencies found at the time of the visit. | A 000 | | |
| A 052 SS=D | 58A-5.0185(3) FAC Medication - Assistance with Self-Admin<br><br>(3) ASSISTANCE WITH SELF-ADMINISTRATION.<br>(a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least 18 to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.<br>(b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.<br>(c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record. | A 052 | | |

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(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(4) Assistance with self-administration does not include:
(a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.

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| A 052 | Continued From page 2<br><br>(c) Administration of medications through intermittent positive pressure breathing machines or a<br>(d) Administration of medications by way of a tube inserted in a cavity of the body.<br>(e) Administration of preparations.<br>(f) Irrigations or debriding agents used in the treatment of a skin condition.<br>(g) , or preparations.<br>(h) Medications ordered by the physician or health care professional with prescriptive authority to be given " as needed, " unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.<br>(i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review and interviews, the facility failed to follow the standard practices of providing assistance with self-administered medications. Specifically:1). Failure to ensure a licensed employee provided medication administration to residents who require this service for 4 out of 7 residents observed during the medication observation pass (Resident #11, # 15, #16 and #18); 2) Failure to ensure a licensed employee provided medication administration for 1 out of 10 sampled residents (Resident #13); 3) failure to ensure the method of administration of medication was in accordance with the manufacturer's recommendations; and 4). Failure to ensure Universal Precautions in Hand Washing was practiced when assisting residents with medications. | A 052 | | |

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The findings include:

1. Review of the record for resident #11 revealed the most recent health assessment (1823) dated [redacted] documented the resident "Needs Assistance with Self-Administration of Medications".

Observations on [redacted] at 9:22 AM during the medication pass with the Med Tech preparing the medications for Resident #11 on the Main Unit revealed: two medications were crushed and one capsule was opened and the contents poured into the apple sauce with the crushed medications and mixed together. The capsule was opened by the Med Tech using her fingers (no gloves). During the medication pass. the Med Tech said the resident has trouble swallowing so medications are crushed and put in apple sauce. She said the the resident is total care, cannot assist with medication, and required administration of all medications.
The Med Tech put on a pair of gloves and administered nasal spray into each of the resident's nostrils. She then tried to tilt the resident's head back and using the same gloved hands administered one eye drop to each eye. She then administered the crushed medications via a spoon into the resident's mouth. The resident kept spitting it out and would not swallow it. On [redacted] at 9:25 AM, the private duty aide said the resident had just finished eating breakfast. The Med Tech said "can't get him to swallow meds so will get him later" and left the [redacted] 9:29 AM. The Med tech said she would try later.
At 10:37 AM, the same Med Tech prepared medications again, crushed, opened MaxiVision (capsule) with fingers and put in crushed

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medications. The LPN (licensed practical nurse) came by at 10:38 AM, asked if she could do anything to help, the Med Tech said will try giving Resident #11 medications again and requested more apple sauce from the LPN. She then mixed the medications in apple sauce, went to resident's , and administered the medications to the resident via spoon without difficulty after she instructed the resident to 'take & swallow'. The Med Tech left the and did not wash or sanitize her hands, and proceeded to the next resident's medication preparation.

2. Review of the record for Resident #15 on the West Unit (secured) revealed the most recent health assessment (1823) of documented the resident "Needs Assistance with Self-Administration of Medications".

Observation of the Med Tech on the West Unit (secure unit) on at 12:24 PM revealed she prepared the eye drops ordered for Resident #15. She said 'I am going to give the resident the eye drop before lunch comes'. The Med Tech went to where the resident was sitting at the dining tilted the resident's head back slightly, pulled down on the lower eye lid and and administered the eye drop to the left eye. Interview with the Med Tech revealed she administered the eye drop and the resident did not help her.
The Med Tech was not observed to wash or sanitize her hands prior to the preparation or administration of the eye drops. She did not wash her hands or sanitize them after administering the drop or before going to the next resident (Resident #16 - see below).

3. Review of the most recent Health Assessment (1823) by the Health Care Provider (physician)

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| A 052 | From page 5<br>dated for Resident #16 revealed the resident "Needs Medication Administration".<br><br>Observation of the Med Tech during the 1 PM medication pass on at 12:32 PM, on the West Wing (secured) in the Dining the LPN nurse standing nearby, revealed she prepared the medication for Resident #16. She then went to the resident, who was sitting at the dining put the souffle cup up to the resident's mouth and poured the medication into the resident's mouth. The resident did not assist the Med Tech. Interview with the Med Tech revealed the resident cannot assist with medication so she administers it to the resident.<br><br>4. Review of the most recent Health Assessment (1823) by the Health Care Provider (physician) dated for Resident #18 revealed the resident "Needs Assistance with Self-Administration of Medication".<br><br>Observation of the Med Tech during the 1 PM medication observation pass on at 12 :50 PM, on the West Unit (secured) in the dining revealed the Med Tech prepared resident #18's medication and mixed it whole in apple sauce. The Med Tech then administered the medication to the resident via a spoon. The resident did not assist the Med Tech. Interview with the Med Tech revealed the resident cannot assist with medications and she administers them to the resident.<br>Interview with the ADON (assistant director of nursing) at approximately 12:50 PM revealed the policy for the secured unit is that the Med Tech would give the medications around noon time (11 AM, 12 PM, 1 PM) each day, and then she would leave. She said that all of the residents on the West unit (secured unit) required administration | A 052 | | |

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of medications, so the nurses administer the medications on all 3 shifts except around noon time. She said she thought the Med Techs could do this since they have a LNS (Limited Nursing Services) license.

Further observation revealed the Med Tech administered medications to three residents with direct contact and did not wash or sanitize her hands during the whole process. The Med Tech said she thought there was sanitizer in the medication cart. When reviewed with the Med Tech and the nurse, they both agreed there was no handwashing or sanitizing between resident contact, and were not aware it should be done.

5. Review of the manufacturer's recommendations related to the observed eye drops revealed the following: eye drops "If more than one drug is being used, the drugs should be administered at least ten (10) minutes apart"; eye drops "If more than one product is to be used, the different products should be instilled at least 5 minutes apart"; and for , there was no specific recommendation related to a wait time between different eye drops; however, under "Warnings: the same adverse reactions found with systemic administration of renergic blocking agents may occur with administration" ...And under "dosage & administration ...the concomitant use of two renergic blocking agents is not recommended ...and to refer to the Precautions."

6. Review of the most recent Health Assessment (1823) dated for Resident #13 revealed the resident "Needs Medication Administration".

Observation of the Med Tech, on at

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approximately 10:00 AM revealed: the Med Tech prepared the medications for Resident #13. She walked to the resident's entered, gave medications to the resident who took the medications. She then gloved, gave the resident a tissue, and instilled the ordered Isotatol 0.5% eye drops, one drop into each eye at 10:09 AM, without resident assistance. She said 'I need to wait a minute'. The Med Tech waited 50 seconds (clock on resident chair-side table), and without resident assistance, instilled the next ordered eye drops, 0.1%, into each eye. The Med Tech said 'will wait another minute'. The Med Tech waited 35 seconds; and then instilled the 3rd ordered eye drop, 1%, into the left eye. She then left the and did not wash or sanitize her hands. She continued with preparation of the next resident's medication.

7. Observation revealed the Med Tech during the morning medication pass on at approximately 9:30 AM, throughout the 5 observed medication passes, revealed the Med tech administered medications or assisted with self-administration to all 5 residents on the Main Unit, having direct contact with each and did not wash or sanitize her hands during the process. During the medication pass, this was reviewed with the LPN (Licensed Practical Nurse) Supervisor, who agreed there should be hand washing or sanitization between resident contact. When reviewed with the Med Tech and the LPN, they both agreed there was no handwashing between resident contact. The Med Tech was not aware it should be done.

8. Observation of the West Unit (secured) during the noon medication pass at approximately 12:30 PM on throughout the 3 observed medication passes in the dining

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| A 052 | Continued From page 8<br><br>the Med Tech was observed to administer medications to 3 residents, having direct contact with them, and did not wash or sanitize her hands during the process. She said she thought there was sanitizer in the medication chart but wasn't sure, and went to look. When reviewed with the Med Tech and the nurse LPN at this time, they both agreed there was no handwashing between resident contact, and were not aware it should be done.<br><br>Class III | A 052 | | |
| A 053 SS=D | 58A-5.0185(4) FAC Medication - Administration<br><br>(4) MEDICATION ADMINISTRATION.<br>(a) For facilities which provide medication administration a staff member, who is licensed to administer medications, must be available to administer medications in accordance with a health care provider ' s order or prescription label.<br>(b) Unusual reactions or a significant change in the resident ' s health or behavior shall be documented in the resident ' s record and reported immediately to the resident ' s health care provider. The contact with the health care provider shall also be documented in the resident ' s record.<br>(c) Medication administration includes the conducting of any examination or testing such as . . . . . ] glucose testing or other procedure necessary for the proper administration of medication that the resident cannot conduct himself and that can be performed by licensed staff.<br>(d) A facility which performs clinical laboratory tests for residents, including . . . . . ] glucose testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of | A 053 | | |

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1988 (CLIA) and Part I of Chapter 483, F.S. A valid copy of the State Clinical Laboratory License and the CLIA Certificate must be maintained in the facility. A state license or CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a State Clinical Laboratory License or a CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents ' own equipment. Information about the State Clinical Laboratory License and CLIA Certificate is available from the Clinical Laboratory Licensure Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)487-3109.

This Statute or Rule is not met as evidenced by:
Based on observation, interviews and record review, the facility failed to ensure that residents who had a Health Care Provider (physician) order to "Administer Medications" were administered medications by a licensed nurse, for 3 of the 10 sampled residents related to medication observation pass (Residents # 5, #13 and #16).

The findings include:

Review of the most recent Health Care Providers orders for Residents #5, #13, and #16 revealed the residents: "Need Medication Administration". The Licensed Practical Nurses (LPN's) who were working on the units did not administer the all of the medications, so they were administered by the Med Techs.

1. Review of the most recent Health Assessment (1823) by the Health Care Provider (physician)

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dated 5/21/[illegible] Resident #5 revealed the resident "Needs Medication Administration". Observation of the Med Tech, on the Main Unit, on [illegible] approximately 9:35 AM revealed she prepared the medications for Resident #5, went to the resident's room [illegible] the resident with the medications.

2. Review of the most recent Health Assessment (1823) by the Health Care Provider (physician) dated [illegible] Resident #13 revealed the resident "Needs Medication Administration". Observation of the Med Tech, on 10/08 [illegible] approximately 10:00 AM revealed: the Med Tech prepared the meds for Resident #13. She walked to the resident's room, [illegible] gave meds to resident who took the meds without assistance. She then gloved, gave the resident a tissue, and instilled the ordered Isotatol 0.5% eye drops, one drop into each eye at 10:09 AM, without resident assistance. She said 'I need to wait a minute'. The Med Tech waited 50 seconds (clock on resident chair-side table), and without resident assistance, instilled the next ordered eye drops, Alphagan .1%, into each eye. The Med Tech said 'will wait another minute'. The Med Tech waited 35 seconds; and then instilled the 3rd ordered eye drop, Azopt 1%, into left eye.

3. Review of the most recent Health Assessment (1823) by the Health Care Provider (physician) dated 8/22/[illegible] Resident #16 revealed the resident "Needs Medication Administration". Observation of the Med Tech during the 1 PM medication pass on [illegible] 12:32 PM, on the West Wing (secured) in the Dining Room [illegible] LPN standing nearby, revealed she (Med Tech) prepared the medication for Resident #16, She then went to the resident who was sitting at the dining room [illegible] the souffle cup up to the

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| A 053 | Continued From page 11<br><br>resident's mouth and administered the medication into the resident's mouth. The resident did not assist the Med Tech. Interview with the Med Tech revealed the resident cannot assist with medication so she administers it to the resident.<br><br>Class III | A 053 | | |
| A 092 SS=D | 58A-5.020(1) FAC Food Service - General Responsibilities<br><br>Food Service Standards.<br>(1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall:<br>(a) Be responsible for total food services and the day to day supervision of food services staff.<br>(b) Perform his/her duties in a safe and sanitary manner.<br>(c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets.<br>(d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interviews and record review, the facility failed to ensure food service operations were performed in a safe and sanitary manner. This had the potential to affect all 98 residents of the facility.<br><br>The findings include: | A 092 | | |

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A review of the facility's food service operations was conducted [redacted] beginning at 9:20 AM with the facility's food service designee (FSD) (present for most); the following concerns were noted:

1. At 12:45 PM, lunch for most of the residents in the west wing secured unit was observed on a heated steam table. The pureed lunch for four residents was observed stored on a counter with no heat source to maintain safe food temperatures; there appeared to be insufficient space in the steam table to accommodate the pureed food. Staff did not attempt to serve the residents the pureed food first although three of the four were present when the food was served. In an interview conducted at that time, a dietary aide confirmed storing the pureed food on the counter was normal practice. In an interview conducted on [redacted] at 12:52 PM, the FSD acknowledged this practice as unacceptable.

2. At 12:54 PM, signs of water damage was observed on a large ceiling tile in the kitchen near a two-compartment sink; a pipe about a half-inch in diameter protruded from the ceiling tile and water was dripping on to the kitchen floor at a moderately fast rate. In an interview conducted at that time, the FSD stated it was related to the air conditioning system.

3. The icemaker machine was observed with dark and light-colored soil around the door opening; minor multi-colored matter was observed along ledges inside the ice bin area. This had the potential to contaminate the food. The FSD acknowledged these concerns at the time of observation.

4. The following areas and equipment were observed to be excessively soiled, dusty and/or

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|---|---|---|---|
| | AL11963720 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PLACE AT VERO BEACH, THE | 3855 INDIAN RIVER BLVD VERO BEACH, FL 32960 |

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| A 092 | Continued From page 13<br><br>with food debris:<br>- counter-top food mixer<br>- lids to the sugar and flour bins<br>- the fans and housing in the walk-in cooler<br>- the char-grill, especially on the inner/outer sides<br>- the underside of the broiler unit<br>- two large stove hoods<br>- six large plastic ceiling light covers<br>- the interior housing in the under-cabinet reach-in cooler near the sandwich preparation area<br>The FSD acknowledged the concerns as they were observed.<br><br>These concerns were discussed with the facility's director of nursing on [redacted] at 3:30 PM.<br><br>Class III | A 092 | | |
| AN278 SS=D | 58A-5.031(3) FAC LNS - Records<br><br>(3) RECORDS.<br>(a) A record of all residents receiving limited nursing services under this license and the type of service provided, shall be maintained.<br>(b) Nursing progress notes shall be maintained for each resident who receives limited nursing services.<br>(c) A nursing assessment conducted at least monthly shall be maintained on each resident who receives a limited nursing service.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure that 2 of 2 sampled residents receiving limited nursing services, had a nursing assessment completed (Residents #2 | AN278 | | |

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| AN278 | Continued From page 14 | AN278 | | |

and #5).
The findings include:
Review of the facility policy for LNS (Limited Nursing Services) revealed: "Monthly Summary /Assessment: The licensed nurse will record a monthly summary/assessment on the residents' progress notes each month. This summary/assessment is a written review of information collected from observation of and interaction with a resident, a resident's record and other relevant progress. It reviews the resident's condition and problems that may have occurred during the month. The summary/assessment will evaluate and state if the resident meets the eligibility for continued stay. Problems noted that may affect the residents' ability to meet continued stay criteria will immediately be brought to the attention of the Director of Resident Services." There is no mention in the policy provided that the resident's assessment or summary of care will be reviewed or supervised by an RN (registered nurse) as per Chapter 464 of the Florida Statutes.
An interview was conducted with the Registered Nurse (RN), who has an agreement with the facility for provisions under the LNS license, on 10/10 [redacted] approximately 11:20 AM. She said the monthly summaries the LPNs (licensed practical nurses) complete are not a nursing assessment as it only includes observations of the resident as to what the resident can do and not do in activities of daily living. Review of the blank monthly summary form included "Method of medication administration. Level of consciousness, [redacted] of Daily Living, Ambulation/ Transfer ability, Appetite, Continent, Socialization, and Additional Comments/Information " . Further interview with the RN at approximately 11:50 AM revealed the monthly assessments are not a nursing assessment. She said a nursing assessment

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| AN278 | Continued From page 15 | AN278 | | |

would constitute more of a systems' check in which there are vital signs, lung sounds, [redacted] sounds and a review of the resident's overall well-being.
Review of the 2012 Florida Statutes, in Title XXXII, Regulation of Professions and Occupations, Chapter 461.003 for Nursing revealed under the following sections: (16) "Licensed practical nurse " (LPN) means any person licensed in this state to practice practical nursing. And (19) " Practice of practical nursing " means the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist. A practical nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing." For Practice of Professional Nursing, (Registered Nurses, RN), Under (20) " Practice of professional nursing " means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of [redacted] biological, physical, and social sciences which shall include, but not be limited to: (a) The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others."
An interview with the LPN supervisor on the Main unit and the LPN on the West unit (secured) on [redacted] at 2 PM revealed the nursing assessments with summaries are completed on

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| AN278 | Continued From page 16<br>all residents by the LPN's. Interview with the Director of Nursing (LPN) at approximately 3:20 PM confirmed nursing summaries are completed monthly on the residents by the LPN's and there is no RN who has supervised or reviewed the assessments/monthly summaries. There was no identified RN in the facility at the time of the survey.<br>Review of two records revealed:<br>1. Review of the record for Resident #2 revealed the resident was placed on LNS (Limited Nursing Services) on with a physician order to straight the resident every shift. There were monthly nursing summaries from 2012 to 2012 completed by the LPN, but none for 2012. There was no evidence a nursing assessment that included the resident's overall well-being or of the residents systems, i.e. lung sound, sounds, extremities, or vital signs. Interview with the LPN on the West unit on at 12 PM revealed she is not aware of any nursing assessments that are conducted or reviewed by an RN or that they needed to be reviewed by an RN. Further review of these monthly summaries did not indicate any service that was required under the limited nursing services.<br>2. Review of the record of Resident #5 revealed the resident received LNS beginning . There was no nursing assessment that included review of the resident's overall well-being or of the residents systems, i.e. lung sound, sounds, extremities, or vital signs. Review of the monthly summary competed revealed it was completed by the LPN on the unit. The summaries did not indicate any service that was required under the limited nursing services. The resident's most recent health assessment by the health care provider was dated .<br>Interview with the LPN on the West unit on | AN278 | | |

Agency for Health Care Administration

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| AN278 | Continued From page 17<br>_____ at 12 PM revealed she is not aware of any nursing assessments that are conducted or reviewed by an RN or that they needed to be reviewed by an RN.<br><br>Class III | AN278 | | |

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
The Place At Vero Beach
3855 Indian River Blvd
Vero Beach, FL 32960

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2012 by a representative from 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Monica Thurman Smith

for Arlene Mayo-Davis
Field Office Manager

AMD/ls
Enclosure

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