STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968825	**09/12/2018**
NAME OF PROVIDER OR SUPPLIER **CRISTAL PALACE RESORT PB LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1881 PALM BAY RD NE** **PALM BAY, FL 32905**	

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0000 - Initial Comments

A Relicensure survey with Extended Congregate Care (ECC) was conducted from . . - . . . Cristal Palace Resort PB, LLC, License #12660, had deficiencies at the time of the visit.

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observations, record reviews and interviews, the facility's administrator
1) failed to oversee the operation and management of the facility to prevent the systemic breakdown of facility operations and ensure the facility's ability to provide necessary care, training (staff A, B, D & E), provide a safe, decent and home-like environment in which to provide for the safe care of the residents,
2) failed to be free of hazards regarding the physical plant,
3) failed to be in compliance with fire department, local emergency management and building codes before modifications were made,
4) failed to honor resident rights and grievances (#30),
5) failed to be in compliance with medication disposal (#18),
6) failed to ensure unlicensed staff follow health care providers orders (#14),
7) failed to submit adverse incident electronic reports (#8, 30 & 31),
8) failed to submit emergency plans,
9) failed to have emergency water,
10) failed to obtain accurate resident health assessment forms (#4, 13, 15, 23, 33 & 34),
11) failed to have required documents for residents' records including weights and assessments (#23 & 31), and
12) failed to obtain an accurate admission and discharge log (#31).

Findings:

During the Relicensure survey, annual survey, complaint investigation and revisits conducted on . . . . , ... , ... , it was determined that the administrator failed to oversee the operations and management of the Assisted Living Facility.

1. Review of the Adverse Incident Report, Day 1 or 15 day, revealed reports, previously cited, were required to be submitted to the agency as follows: Resident #30 was cited in Complaint Investigation #2016007263 on . Upon revisit on and , there were no Day 1 or Day 15 adverse reports available for review. The police were called to the facility because the resident was missing two medication cards of , which contain approximately 30 pills per card.

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Resident #31 was previously cited in Complaint Investigation #2016009950 on . Resident #31's record revealed he was on the current census noted to be living in A. Staff F stated that resident #31 no longer resided at the facility. She said she did not remember when he left the facility, but he did not want to live there anymore. During the tour on , it was discovered that all of his belongings were still in the . Review of the admission/discharge log revealed resident #31 was discharged on . The column on the facility's discharge log for location of the resident after discharge was blank. On at 2:05 PM, the administrator stated he was no longer in the facility, but had not removed his belongings. She said his daughter stated he was "traveling" and he had his own car. The administrator was not sure when he left the facility. On at 6:55 PM, the resident's daughter said, "He's in NC [North Carolina]. He left in , [2017], not sure of the exact date. It was his choice to leave, I believe that is what the facility told me. My father is , . He is having a episode right now. He is on his own; he is not well. I know his belongings are there. He bought a car and can get around. They called me on Friday, to give me his rent bill. I have been in contact with him, but until [ ], I did not know they still considered him a resident." Resident #31's record did not contain any notes regarding his absence from the facility and documentation or investigation as to where he might be.

Resident #8 was previously cited in Complaint Investigation #2016009950 on . On at 11:30 AM, resident #8 said she was prescribed , and she had not received it since because when the new pharmacy took over her medications, the staff said it was not on her Medication Observation Record (MOR) and she could not have it. On at 9 AM, the facility was asked to obtain evidence from the old pharmacy when the last order was written for the , because it was not in the record. The pharmacy faxed over the refill history, and it noted on , the pharmacy had sent 120 pills, which was a two-month supply. According to the sheet, only 60 pills were given, with the last one being on . There should have been another 60-pill package. The facility staff search for the medication and said they could not locate the remaining pills that were delivered on . On , the police conducted an investigation and the report number was provided to the agency. On at 11 AM via telephone, the administrator was asked if the facility had completed the Adverse Incident Report in reference to the police completing an investigation for the missing . The administrator said she would check and call the agency staff back. On at 1:45 PM, the front clerk called the Agency for Health Care Administration (AHCA) on behalf of the administrator to say the facility had not completed an adverse incident report as required. A telephone call was made to AHCA's area office on at 11 AM to inquire if the facility had submitted the above adverse incident reports as required. After review of the electronic submissions for the facility by the agency's area office staff, electronic submissions for the above residents were not found.

On at 12:20 PM, the current administrator was not aware that the above incident reports were to

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be submitted to AHCA.

2. Resident #15's record revealed a facility admission date of . A most recent 1823 health assessment form, dated , indicated she required both medication administration and assistance with self-administered medications. The record did not contain documentation to indicate the facility contacted the health care provider for clarification. On at 3:20 p.m., the director of nursing (DON) said the facility's consultant instructed her to check both options on the 1823 to cover herself.

Resident #4's health assessment report 1823, dated , did not indicate if the resident needed assistance with self-administration of medications or needed administration of medications. That portion of the 1823 form was blank.

Resident #23's updated 1823 form, dated , listed diagnoses of , , high , and , . Per the 1823 form, she needed assistance with self-administration of medications as well as administration of medication.

Resident #33's updated 1823 form, dated , listed diagnoses of moderate , , , , , , , and chronic pain. Per the 1823 form, she needed assistance with self-administration of medications as well as administration by a licensed professional.

Resident #34's 1823 form, dated , listed diagnosis of moderate 's , and was independent with all activities of daily living. Per the 1823 form, she needed assistance with self-administration of medications as well as administration of medication.

Resident #13's original 1823 health assessment undated by the healthcare provider, reflected the resident was admitted into facility on . The current 1823 form was completed on .

On at 1:30 PM, the DON confirmed these findings.

3. Resident #18's record revealed a facility admission date of . A most recent 1823 health assessment form, dated , indicated she required assistance with self-administered medications. The resident's , 2018 MOR revealed all of her 8 AM scheduled medications on were blank and not signed as given. There was neither documentation on the MOR nor in her record to indicate why the medications were not signed. On at 10:45 AM, the findings were discussed with the DON, and at 2 p.m., she said she did not know why the medications were not signed as given and was unable to provide additional documentation.

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Resident #34's [redacted] and [redacted] 2018 MOR had blank spaces and there were no notations that explained why the medications was signed not given.

[redacted] 2018 MOR listed [redacted] 600-[redacted] D3 2000 units (u.) twice a day ( ) at 8 AM and 5 PM was blank on at 5 PM and at 8 AM, Cranberry 250 milligrams (mg.) daily (QD) at 8 AM was blank on [redacted], Donezapil 10 mg. in the evening (PM) was blank on [redacted] 500 mg. QD at 10 AM was blank on , 10 mg. at 8 AM and 5 PM was blank on [redacted] in AM, [redacted] 50 mg. QD, [redacted] ER 1000 mg. and [redacted] D3 5000 u. and [redacted] E 400 mg. at 8 AM were all blank on .

[redacted] 2018 MOR listed Cranberry 250 mg. QD, , 500 mg. QD, 50 mg. QD, [redacted] 10 mg. at 8 AM and 5 PM, [redacted] ER 1000 mg. and [redacted] D3 5000 u. and E 400 mg. at 8 AM were all blank on [redacted] 600, D3 2000 u. with meals was blank on [redacted] at 5 PM, [redacted] 500 mg. QD at 10 AM was blank on [redacted] 10 mg. at 8 AM and 4 PM was blank on at 5 PM and at 8 AM, QD at 8 AM was blank on [redacted] at 8 AM, [redacted] 50 mg. QD, [redacted] ER 1000 mg. and [redacted] D3 5000 u., and E 400 mg. were blank on /18 at 8 AM.

, 2018 MOR listed 10 mg. at 8 AM and 4 PM and was blank on at 4 PM. Donezapil 10 mg. in PM was blank on [redacted] at 6 PM.

Resident #33's [redacted] and [redacted] MORs had blank spaces, and there were no notations that explained why the medications were not given.

[redacted] 2018 MOR listed , 81 mg. QD and was blank on , 10 mg. at bedtime (HS) was blank on [redacted] 0.1 mg. at 8 AM and 5 PM was blank on [redacted] in PM and in AM, 100 mg. three times a day ( ) at 8 AM, 12 PM and 5 PM was blank on AM and [redacted] AM.

[redacted] 2018 MOR listed [redacted] 81 mg. QD and was blank on [redacted] 0.1 mg. at 8 AM and 5 PM was blank on AM, Floranex one QD was blank on and Proxetine 10 mg. QD was blank on [redacted].

On at 4 PM, the DON said that most likely the staff gave the medications and forgot to sign; sometimes during the day there is only one medication technician, an unlicensed staff, who assists with self-administration of medication.

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Resident #12's [illegible] and [illegible] 2018 MORs revealed blank spaces, and there was no way to determine whether the resident received the medications. [illegible] 0.004% Solution 1 drop in each eye HS was blank on at 8 PM, [illegible] 0.5 mg. 1 was blank at 5 PM on and 8 AM on [illegible] B-1 100 mg. QD was blank on [illegible] at 8 AM and at 8 AM on [illegible]. [illegible] SOD DR 40 mg. QD was blank on at 7 AM, and Iprat-Albut 0.5-3(2.5) mg. 1 vial [illegible] every six hours while awake was blank on [illegible] and [illegible] at 6 PM.

Resident #14's [illegible] and [illegible] 2018 MORs revealed blank spaces, and there was no way to determine whether the resident received her medications. 50 mg. 1 tablet HS for [illegible] was blank on [illegible] at 8 PM and [illegible] at 9 PM, [illegible] 5-325 mg. was blank on at 5 PM, [illegible] Succ ER 100 mg. HS was blank on and [illegible] at 9 PM, Doc-Q-Lace 100 mg. HS for [illegible] was blank on [illegible] and [illegible] at 9 PM, [illegible] 400 mg. and 2 capsules (800 mg.) HS was blank on at 5 PM and 9 PM and [illegible] at 9 PM, [illegible] 250-50 Diskus inhale one puff every 12 hours was blank at 9 PM on [illegible] and at 7 AM on [illegible] 2% cream apply [illegible] to toe nail QD was blank on [illegible], [illegible] 5 mg. QD was blank at 8 AM on [illegible] 10 mg. QD for [illegible] was blank at 8 AM on [illegible] 14 mg./24 hr. apply 1 patch [illegible] QD was blank on at 8 AM, [illegible] 20 mg. QD was blank on [illegible] at 8 AM, [illegible] 100 mg. QD was blank on at 8 AM, 1000 micrograms (mcg.) QD was blank on at 8 AM, D3 1000 u. QD was blank on [illegible] at 8 AM, [illegible] 3 mg. HS was blank at 9 PM on [illegible], and 40 mg. HS was blank on at 9 PM.

On at 3 PM, the DON confirmed these findings.

4. Resident #3's record revealed she was admitted to the facility on . Her most recent health assessment 1823 form was dated [illegible] and reflected that she required assistance with self-administration of medications.
Review of the resident's [illegible] and [illegible] 2018 MORS revealed on [illegible] and [illegible], the resident did not receive 16 of the 25 prescribed medications. The MOR documented "withheld per DR/RN (doctor/registered nurse) orders."

On [illegible], the following medications were circled on the MOR as not given: [illegible] 10 mg. QD, 10 mg. [illegible] SR 150 mg. QD, Doc-Q-Lace 100 mg. softgel 2 capsules for [illegible] DR 60 mg. 2 capsules QD, [illegible] 1 mg. QD, [illegible] 20 mg. QD, [illegible] 400 mg. [illegible] 150 mg. QD, [illegible] 200 mcg. QD, [illegible] sulf ER 30 mg. every 8 hours, [illegible] tablet QD, [illegible] Sod DR 40 mg. QD, [illegible] CL ER 20 milliequivalents (mEq) , and D3 1000 u. QD.

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On , the following medications were circled on the MOR as not given: Tears 1.4% 1 drop in affected eye(s) , , ( ) 81 mg. QD, 10 mg. , , , SR 150 mg. QD, Doc-Q-Lace 100 mg. softgel 2 capsules for , , DR 60 mg. 2 capsules QD, PRP 50 mg. NS 1 squirt in each nostril , 20 mg. QD, , 400 mg. , , 150 mg. QD, , 200 mg. QD, , sulf ER 30 mg. every 8 hours, QD, , Sod DR 40 mg. QD, and D3 1000 u. QD.

On at 1:30 PM, the DON stated they held resident #3's medications on the days she went out for treatment. When asked why only some medications were held and the medications held were different on and , she did not have an explanation. She was unable to find an order from the provider for the medications to be held.

5. Resident #18's record revealed a facility admission date of . A most recent 1823 health assessment form, dated , indicated she required assistance with self-administered medications. A health care provider's order, dated , indicated , and , were both discontinued. On at 1:15 p.m., a request was made to review all discontinued medications that were centrally stored. Caregiver F said anytime a resident's medications were discontinued, the facility sent them to the pharmacy for destruction. On at 11 a.m., a representative from the pharmacy said that when the resident's non- medications were discontinued, the facility sent them to the pharmacy, where they were destroyed. He said resident #18's , and , were destroyed by the pharmacy. Resident #18's record did not contain documentation to indicate the facility returned the remaining quantity of the , and , to the resident. On at 2 p.m., the DON confirmed the findings and said resident #18 did not have family and said "why would I return them to a resident?" A pharmacy disposition form, dated , indicated 38 , tablets and 19 , tablets were destroyed because they were discontinued.

6. On at 10:40 AM, over the counter medications of a bottle of , a bottle of rubbing , a bottle of , and a container of foot cream were found in resident #13's . At 10:45 AM, resident #13 stated that she buys the over the counter medications when she goes on the facility field trips to the stores every week. Resident #13's 1823 Health Assessment, dated , reflected the resident required assistance with self-administration of medications.

On at 10:20 AM, over the counter medications of a bottle of , and Homeopathic were found in resident #17's . At 10:25 AM, resident #17 stated that she has her bottle of , and homeopathic medicines to help her with ongoing pain in her body.

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On at 10:30 AM, the DON explained that any residents requiring assistance with self-administration of medications identified on the 1823 Health Assessment form must have all medications, including over the counter medication, stored in a central location with the resident's name written on the over the counter medications. On at 1:30 PM, the DON said she observed the over the counter medications in residents #13 and #17's and confirmed the findings.

7. Resident #19's , 2018 MOR contained an entry for -S tablets 2 tablets QD as needed (PRN). However, the MOR did not contain documentation to indicate the circumstances under which it would be appropriate for the resident to request the medication. Resident #19's recent 1823 health assessment form, dated , indicated he required assistance with self-administered medications. A medication list attached to the 1823 contained an entry for -S tablets 2 tablets by mouth QD PRN but did not contain the circumstances under which it would be appropriate for the resident to request the medication. Additionally, the resident's record did not contain documentation to indicate the facility contacted a health care provider to request revised instructions.

Resident #18's record revealed a facility admission date of . A most recent 1823 health assessment form, dated , indicated she required assistance with self-administered medications. The resident's , 2018 MOR contained an entry for HFA 90 mcg. inhaler, 2 puffs by mouth every 6 hours PRN but the MOR did not contain documentation to indicate the circumstances under which it would be appropriate for the resident to request the medication. Resident #18's record did not contain documentation to indicate the facility contacted a health care provider to request revised instructions. On at 10:45 a.m., the findings were discussed with the DON. At 2 p.m., the DON confirmed the findings and did not provide additional documentation. At 3:15 p.m., the DON provided a health care provider's order for resident #18's but it did not contain documentation to indicate the circumstances under which it would be appropriate for the resident to request the medication.

8. Observation in the kitchen on at 12 PM found a 100-gallon plastic barrel container. Inside was a dark liquid with white substance floating on top. Immediately after the observation, an interview with the Food Manager confirmed that this was the facility's 3-day emergency water on hand, and that this was already here prior to her hire date 4 months ago. She further stated that she just ordered 25 cases of water today. On at 1:45 PM, the Administrator was informed that the facility did not have sufficient 3-day emergency drinking water on hand for the residents. He confirmed the finding at that time.

9. Observations made on at 10:15 a.m. revealed the entire carpet in the hallways of the residents' on the first floor, in front of the elevators, and in the lobby contained black stains. The tile in the elevator was cracked, and the bottom of the wall on the outside of resident 112 and 114 had plaster chipped away and a metal support showing through. The baseboard between resident

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125 and 127 was cracked, the baseboard next to was from the wall, and the carpet in front of resident 225 and 233 had black stains. On at 11:30 a.m., the findings were shown to the administrator and he confirmed the findings.

On at 10:20 AM in resident #17's a bag of trash on the floor behind the front door inside the . On the wall inside the by the front door was drywall damage with paint chips on the floor exposing metal in the baseboard.

Observation on at 10:30 AM found dark carpet stains in front of the following 205, 212, and 224. had black and white carpet stains in front of the door. On the right side of the wall in the front of the , metal was exposed, and there were scrapes and a crack in the wall when entering the . Between 206 and 208, the baseboard was missing. At 2 PM, the maintenance director said that he would be making the repairs and was waiting to have the roof repaired before replacing the carpets.

Tour of the facility in the residence hallways on the first and second floor revealed stained carpets throughout both hallways, including in the elevator lobbies on both floors. There were black stains and signs of wear overall. Some had white stains in front of the resident doors. Photo of the carpet in front of was obtained. There was a black substance on the inside bottom of the fire extinguisher box located on the wall close to . There were 2 holes in the ceiling at the front entrance of the facility lobby. Buckets had been placed under each hole to collect water coming in through the holes. Photographic evidence was obtained. In the main part of the facility lobby, multiple ceiling tiles were missing, air vents had a black substance on them, there were water stains, chipped paint, and leaking through the skylights. Photographic evidence was obtained.

10. On at 11:35 AM, resident #14's half-bed rails on a hospital bed. At 11:40 AM, resident #14 was asked if she could use her half-bed rails on her own, requiring lifting them up and down. She answered "Yes", she can. She was asked to demonstrate lifting the half-bed rail up and down but was not able to lift them up or down. The half-bed rails were moving side to side and were not stable. The resident stated that she had bought the half-bed rails from resident #26, and resident #27 installed them for her. Resident #14 stated that earlier this morning on , the nurse came to do work and pulled the half-bed rails up and down. The resident stated that she never puts her half-bed rails down, she always leave them up because she holds onto them at night while she is sleeping. On at 11:50 AM, the DON confirmed the finding and stated that she was not aware that the half-bed rails were in resident #14's . Resident #14's record did not contain any orders from the healthcare provider for the half-bed rails, and there was no documentation on file that the use of half-bed rails used as physical was discussed and reviewed by the healthcare provider.

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11. On at 11 a.m., resident #30 said the facility did her laundry and one of her dresses was missing. She spoke with the administrator about it on two previous occasions and was told the facility was not responsible for missing or damaged personal items. At 10:55 a.m., a review of the facility's grievance log did not reveal any documentation to indicate the facility logged the resident's grievance. Resident #30's record did not contain a narrative report regarding her reports of a missing dress. The facility's grievance policy and procedure reflected that anytime a resident had a concern with any service received, the concern would be entered in the grievance log. The executive director had 24 hours to investigate the complaint and get back to the resident. The executive director would speak with the resident and document a narrative report with a resolution in the resident's chart. At 11:20 a.m., the administrator said when he first began his employment at the facility, resident #30 told him that her dress was missing but staff told him it was an old complaint and the dress was found years ago. He said he did not follow the facility's grievance policy.

12. Resident #2's record revealed an informed consent dated allowing unlicensed staff to assist with self-administration of medications for the resident. The consent form included an option to circle "will" or "will not", indicating if this would be supervised or not supervised by a licensed nurse but neither option was circled. Photographic evidence was obtained. On at 11:15 AM, the DON confirmed the consent form did not include that information.

13. On at 2 PM, resident #23 stated the staff helped her with dressing, bathing and toileting. She said staff came at 5 AM, changed her, and then she was able to go back to bed and get up at a later time. The resident's record revealed she was admitted on . An updated health assessment report 1823, dated , listed diagnoses of , , high , and , . The 1823 form reflected the resident needed assistance with ambulation, bathing, dressing, toileting and transferring. The record did not contain evidence that her weight was taken at admission, and at least every 6 months for the year 2017.

On at 3:30 PM, resident #33 who said the staff helped her with the showers and gave her medications.
The resident's record revealed an admission date of . The resident's record did not contain any evidence of the resident's weight at least every 6 months for the year 2017.

On at 11 AM, resident #34 said staff helped her with showers and dressing. She said she did as much as she could on her own. Her record revealed she was admitted on . A health assessment report 1823, dated , listed diagnosis of moderate 's , and she was independent with all activities of daily living (ADLs). The record did not contain evidence that the

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resident's weight was taken in the year 2017. The DON provided a "2017 weight" binder. The binder contained tabs and a sheet with the 12 months of the year and the residents' names. However the sheets were blank, and no weights were listed. At 4 PM on , the DON said she was unable to locate any other paperwork from the previous DON.

14. On at 1 PM, the administrator was asked to provide a copy of the Comprehensive Emergency Management Plan (CEMP) and Emergency Power Plan (EPP) approval letters. Review of the documentation provided by the administrator revealed the plan had not been approved because the facility was required to make corrections to the plan and had not done so as of this survey date. At 1:10 PM, the administrator stated he did not have an approved CEMP because they were unable to get a fire inspection. He further stated that they had an extension on the EPP until , 2019. When it was discussed that the extension was for the implementation and not the development and approval of the plan, the administrator stated that since they did not have a fire inspection, and did not have their fire plan approval to send in with the EPP. At 2:30 PM, when asked if they had a generator on the premises, the administrator stated they did not. He stated they had an arrangement to rent a generator in the event of an emergency. He provided a handwritten "rental questionnaire" which was later confirmed as just an application. The administrator confirmed he did not have a signed contract for a generator rental. When asked what the plan was in the event of no electricity, the administrator stated, "We would remain in place. This is a concrete building and we are not at the shore." The administrator confirmed they would not have electricity or a method to cool the facility and residents. At 3 PM, the "Assisted Living Facility Generator Assessment" form was completed with assistance of the administrator. He confirmed they did not have a generator on site, and did not have an approved CEMP, EPP and fire plan. He confirmed in the event of a power outage, they would not be able to cool the facility or provide lighting or refrigeration for food. He confirmed that without an approved plan, they had not informed the residents of the emergency plan.

On at 3:45 PM, the coordinator of the county Emergency Management Office (EMO) stated he was unable to approve a CEMP for the facility. He stated the facility had not submitted any corrections as requested. He was concerned that they did not have a generator on site and did not have a plan for power in the event of an emergency. The EMO coordinator stated Cristal Palace had a Mutual Aid agreement with several other area facilities to receive their residents who have evacuated, but continued to have no plan in place to provide for their own residents. He confirmed the facility had not submitted an Emergency Power Plan as of .

The facility continued to have multiple fire code violations. On at 8:50 AM, the Palm Bay Fire Marshal was contacted and confirmed the facility had outstanding violations. The fire marshal visited the facility during the survey on , and stated he believed there had not been a satisfactory inspection

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in 2018. He stated there were numerous major violations that were never corrected. The fire marshal toured the facility with one of the surveyors and pointed out some of the various violations along the way. At 10:55 AM, in the presence of the surveyor and the facility administrator, the fire marshal stated he saw the preliminary . . 2018 report and refused to sign it or issue a report. He stated that as of the date of the survey, , he still would not be able to issue a satisfactory fire inspection for the facility. On . . . . , the Palm Bay Fire Marshall conducted a new fire inspection at the facility and forwarded a copy to AHCA. The current inspection listed 20 uncorrected violations. Violations included incorrect hardware on fire doors, emergency lighting not repaired, request for a current generator report, all electrical violations to be addressed, locks on hose valves to be removed, replace AC unit that feed all corridors, repair all fire walls, etc. The report documented all corrections must be made by . . . . . or the facility will be reported to local Code Enforcement Board.

15. Resident #2's record revealed the residency contract, dated , which did not include a provision stating a new health assessment 1823 form must obtained every 3 years or when there is a significant change in health status. Resident #18's residency agreement, dated , did not contain the required provision that residents must be assessed upon admission and every 3 years thereafter, or after a significant change. On at 2 PM, the DON confirmed the findings.

16. Caregiver E's personnel record revealed she was hired by contract. The contract not dated. The background screening (BGS) result, dated . . . . . , indicated she was eligible. The result was older than 5 years, and an update BGS was due . Review of the Agency's BGS website on at 1:40 PM revealed caregiver E had an eligible screening effective . . . . . . On . . . . at 2 PM, the administrator stated the BGS result had not been reviewed or printed, and was not in her personnel record.

17. Review of the Agency's BGS website revealed that caregiver E was not on the Clearinghouse roster for the facility. On at 2 PM, the administrator confirmed the contracted caregiver E was not on the roster.

18. Personnel record review for staff D, the administrator, hired on . . . . . , revealed online training certificates for elopement and emergency procedures including evacuation. However, certificates for training specific to the policies and procedures of the facility were not in the administrator's file.

Personnel record review for caregiver E, hired by contract, which was not dated, did not contain evidence to confirm she received in-service training regarding reporting major incidents and adverse incidents and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. A certificate from an Internet training site, dated , indicated 1-hour

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in-service training regarding elopement and wandering. However, there was no evidence that the in-service training was specific to the facility's resident elopement response policies and procedures.

On at 2 PM, the administrator stated he was unable to locate any documentation.

Staff A's personnel record revealed a hire date of . There was no evidence of elopement training, emergency procedures, and evacuation training.

Staff B's personnel recordrevealed a hire date of . There were online training certificates for elopement and emergency procedures both dated . However, there was no documentation to confirm that she received facility specific training of the facility's policies and procedures regarding the trainings.

Staff C's personnel record revealed a hire date of . There were online training certificates dated for elopement and emergency procedures. However, there was no documentation to confirm that she had received facility specific training regarding the facility's policies and procedures regarding the trainings.

On at 3 PM, the administrator confirmed these findings.

Staff E was hired by contract. The contract was not dated. Staff E's personnel record revealed a healthcare provider statement dated that indicated freedom from communicable , including ( ). The review did not reveal any evidence to confirm she obtained freedom of for the year 2018.

On at 2 PM, the administrator stated he was unable to locate any documentation.

Staff B's personnel record revealed a hire date of . The documentation to confirm freedom from communicable and revealed a space for the name of a reader and a space for a physician 's signature. There was a signature in each space but the person who signed the form did not include his or her credentials that included the title and medical license number. There was no way to determine if the form was completed by a health care provider.

On at 3 PM, the administrator confirmed these findings.

19. During a medication pass for resident #15 on at 12:20 p.m., the resident sat on the seat of her walker in the medication . Unlicensed caregiver A unlocked the medication cart, donned

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gloves, removed medication packages from the cart, read the prescription labels aloud, then she popped the pills into a cup. The resident took the pills without assistance. Caregiver A removed a tube of gel from the cart, then she looked in a drawer for the measuring tape that accompanied the medication but was unable to locate it. She then said, "I'll just put it on my finger." She placed some of the gel onto her right first finger from the tip to the middle then she applied the gel to the resident's lower back. After applying the gel, the caregiver found the measuring tape in a drawer of the medication cart. The resident's MOR and the prescription label both indicated the prescribed directions for use for gel was to apply 1-2 grams to affected areas of pain four times a day. The directions required the unlicensed caregiver to judge the amount of gel to be applied, which was not allowed.
When questioned how she knew how much gel to apply to her finger to equal the prescribed amount, caregiver A said she knew the amount she applied to her finger measured 2 grams. When questioned how she decided whether to give 1 or 2 grams, she said the resident requested 2 grams. However, the resident never requested a specific amount of gel during the medication pass. The directions required the unlicensed caregiver to judge the amount of gel to be applied, which was not allowed. At 12:58 p.m., the DON confirmed the findings.

20. Resident #33's , 2018 MOR indicated the resident "was out facility" on and . The MOR did not have any written evidence why she was out of the facility, and did not get her medications. There was no written evidence where she was and if the healthcare provider and responsible party were notified. On at 3:30 PM, the DON said resident #33 was in the hospital because of , and her mother and doctor were aware. She did not write notes but placed the hospital discharge paperwork in her resident record.

Resident #34's , 2018 MOR listed , 5 mg. after lunch and after dinner, and was refused on at 6 PM. The 2018 MOR listed , 5 mg. after lunch and after dinner, and read, "resident declined" on at 1 PM and at 9:25 AM. The , 2018 MOR listed , 5 mg. after lunch and after dinner, and indicated the resident declined on at 6 PM and on at 12:26 PM and 6 PM. On at 3:30 PM, the DON said resident #34 may have been out for an outing or something like that.

Resident #13's 2018 MORs revealed that resident declined 11 medications on for , 100-25 mcg., 600 mg., , 75 mg., 325 mg., 125 mg., 10 mg; MAPAP 325 mg., 500 mg., Spriva Handihaler 18 mcg. Capsule, 50 mg., and 120 mg. There was no documentation or facility progress notes to reflect that the physician was notified.

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On at 1:30 PM, the DON stated she was not aware or was not notified that resident declined her medications on . The DON also stated that there was no facility documentation of the declined medications but documentation was on the MORs. The DON confirmed all the findings.

Resident #15's record revealed an admission date of . A most recent 1823 health assessment form, dated , indicated she required assistance with self-administered medications. The resident's , and , 2018 MORs contained an entry for Sucralfate 1 gram (gm.) to treat . The initials, documented to indicate the medication was given, were circled on , -07, -27, -31 and - . The documentation on the back of the MORs indicated she declined the medication on those dates. The MORs and her record did not contain any documentation to indicate the facility informed the resident's health care provider when she consistently declined the medication. On at 3:20 p.m., the DON confirmed the findings and said she was unable to provide additional documentation.

21. Review of the resident census on at 10 AM noted resident #34 was the only resident who lived on the third floor. Resident #34's record reflected a diagnosis of . At 11 AM, resident #34 said, "There was a man [resident #4] who lived here too but he moved out." She said did her activities in another was originally a resident had been converted to an activities . Observation of this activities some chairs, a table, puzzles boxes and activity books. Resident #4's record reflected a diagnosis of with behavioral outbursts. On at 4:30 PM, the administrator said resident #4 was discharged.

On at 12:30 PM, the administrator was made aware of the observations made earlier that day on the third floor of resident #34. He said he thought the third floor had been approved as a memory care unit. The facility used the third floor as a memory care unit without AHCA authorization, building code and fire inspection approval.

On at 12:05 p.m., resident was converted to a facility medication . Caregiver A was present in the medication the time of the observation and she confirmed the findings. At 3:30 p.m., the administrator confirmed the facility changed resident into a medication he said AHCA was not notified of the change in use of space, as required.

22. Resident #15's record revealed a facility admission date of . An admission 1823 health assessment form, dated , indicated she did not have a communicable which could be transmitted to other residents or staff. A more recent 1823 health assessment form, dated , indicated resident #15 had a diagnoses of , , a communicable which could be transmitted to other residents or staff, which exceeded the continued residency criteria in an ALF.

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Resident #15's record did not contain documentation to indicate the facility contacted the health care provider for clarification or to indicate the facility issued a 45-day notice of discharge.

On . . . . at 1:45 p.m., the findings were discussed with the DON, who confirmed the findings. At 3:20 p.m., the DON said the facility did not have any additional information or documentation to present.

Class II

0167 - Resident Contracts - 58A-5.025 FAC; 429.24 FS

Based on record review and interview, the facility failed to include a provision in the resident agreement contract documenting residents must be assessed by a licensed healthcare provider upon admission pursuant to subsection 58A-5.0181(2) Florida Adminsitrative Code, and every 3 years thereafter, or after a significant change for 2 of 2 sampled resident contracts (#2 &18).

Findings:

1. Resident #2's contract revealed the residency contract, dated , did not include a provision stating a new health assessment must obtained every 3 years or when there is a significant change in health status.

2. Resident #18's residency agreement, dated , did not contain the required provision that residents must be assessed upon admission and every 3 years thereafter, or after a significant change.

On . . . . at 2 p.m., the director of nursing confirmed the findings.

Class

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and interview, the facility failed to develop, submit and maintain a copy of their Emergency Power Plan, and did not notify residents in writing of the plan.

Findings:

On , the administrator was asked to provide a copy of the Comprehensive Emergency Management Plan (CEMP) and Emergency Power Plan (EPP) approval letters. At 1:10 PM, the administrator stated he did not have an approval of the CEMP because they were unable to get a fire

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inspection. He further stated that they had an extension on the EPP until , 2019. When it was discussed that the extension was for the implementation and not the development and approval of the plan, the administrator stated that since they did not have a fire inspection, they also did not have their fire plan approval to send in with the EPP.

When asked if they had a generator on the premises, the administrator stated they did not. He stated they had an arrangement to rent a generator in the event of an emergency. He provided a handwritten "rental questionnaire" which we later confirmed was just an application. The administrator confirmed he did not have a signed contract for a generator rental. When asked what the plan was in the event of no electricity, the administrator stated, "we would remain in place. This is a concrete building and we are not at the shore." The administrator confirmed they would not have electricity or a method to cool the facility and residents.

On at 3 PM, the Assisted Living Facility Generator Assessment form was completed with assistance of the administrator. He confirmed they did not have a generator on site, did not have an approved CEMP, EPP or fire plan. He confirmed in the event of a power outage, they would not be able to cool the facility or provide lighting or refrigeration for food. He confirmed that without an approved plan, they had not informed the residents of the emergency plan.

The facility had multiple current violations of fire code. On at 8:50 AM, the Palm Bay Fire Marshal was contacted and confirmed the facility had outstanding violations. The fire marshal visited the facility during the survey on and stated he believed there had not been a satisfactory inspection in 2018. He stated there were numerous major violations that were never corrected. The fire marshal toured the facility with one of the surveyors and pointed out some of the various violations along the way. On at 10:55 AM, in the presence of the surveyor and the facility administrator, the fire marshal stated he saw the preliminary 2018 report and refused to sign it or issue a report. He stated that as of the date of the survey, , he still would not be able to issue a satisfactory fire inspection for the facility.

On at 3:45 PM, the coordinator of the county Emergency Management Office (EMO) stated he was unable to approve a Comprehensive Emergency Management Plan for the facility. He stated the facility had not submitted any corrections as requested. He was concerned that they had no generator on site and no plan for power in the event of an emergency. The EMO coordinator stated Cristal Palace had a Mutual Aid agreement with several other area facilities to receive their residents who have evacuated, but continued to have no plan in place to provide for their own residents. The county EMO coordinator confirmed the facility had not submitted and Emergency Power Plan as of .

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Class III

Z813 - Results of Screening & Notification In File - 59A-35.090(3)(c), FAC

Based on record review, review of the Agency's background screening website, and interviews, the facility failed to maintain the results of a background screening (BGS) in the personnel record for 1 of 5 caregivers who was in a role that required a background screening (E).

Findings:

On . . . . at 12:53 PM, caregiver E stated her contract with the facility was valid and she had signed it some time ago.

Personnel record review for caregiver E, hired by contract which was not dated, revealed a BGS result dated . . . . . that indicated she was eligible. The result was older than 5 years and due to be done again . . . . .

Review of the Agency's BGS website on at 1:40 PM revealed caregiver E had an eligible screening effective . . . . . .

On . . . . at 2 PM, the administrator stated the BGS result had not been reviewed or printed.

Unclassified

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on the Agency for Health Care Administration's Clearinghouse Website review and interview, the facility failed to register and maintain the employment status of employees within the Agency's Background Screening Clearinghouse for 1 of 5 sampled caregivers (E).

Findings:

Review of the Agency's Background Screening website revealed caregiver E was not on the Clearinghouse roster for the facility.

Personnel record review for caregiver E, hired by contract which was not dated, revealed a BGS result dated . . . . . that indicated she was eligible. The result was older than 5 years and due to be done again . . . . .

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Review of the Agency's background screening website on . . . . . at 1:40 PM revealed caregiver E had an eligible screening effective .

On at 2 PM, the administrator confirmed the contracted caregiver E was not on the roster.

Unclassified