

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments An Assisted Living Facility complaint inspection CCR #2013001966 was conducted on 20-21, 2013. Magdolna Home Care Inc. had licensure deficiencies found at the time of the visit.	A 000			
A 008 SS=D	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 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	A 008			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0009

FL2X11

If continuation sheet 1 of 51

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983
---	--

(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 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, 2010. 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 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	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983
---	--

(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 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 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	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 3 415.1051, 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, it was determined the facility failed to ensure the health assessments (Form 1823) were completed within 30 days of admission, for 4 out of 6 sampled residents (Resident #1, #2, #3 and #5). The findings include: a) Review of Resident #1's health assessment dated _____ noted to be incomplete (admission date _____). The health assessment failed to indicate the resident's diet instructions, whether this individual's needs could be met in an Assisted Living Facility (placement was not marked yes or no) and whether the resident required assistance with medication (yes/no was not marked) and the type of assistance required (self-administration/administration) whether the resident. During an interview with the Administrator at 11 AM on _____ she revealed this was the current health assessment for the resident and no further documentation was available.	A 008		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 b) Review of Resident #2's health assessment dated _____, noted to be incomplete (admission date _____. The health assessment failed to indicate whether the resident required assistance with medication (yes/no was not marked) and the type of assistance required (self-administration/administration) whether the resident _____. During an interview with the Administrator at 11:20 AM on _____, she revealed this was the current health assessment for the resident and no further documentation was available. c) Review of Resident #3's health assessment dated _____, noted to be incomplete (admission date _____. The health assessment failed to indicate whether the resident required assistance with medication (yes/no was not marked). During an interview with the Administrator at 11:35 AM on _____, she revealed this was the current health assessment for the resident and no further documentation was available. d) Review of Resident #5's health assessment dated _____, noted to be incomplete (admission date _____. The health assessment failed to indicate whether the resident required assistance with medication (yes/no was not marked) and the list of medications was not attached to the assessment as indicated, "See List". During an interview with the Administrator at 11:45 AM on _____, she revealed this was the current health assessment for the resident and no further documentation was available.	A 008			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED _____
---	--	--	--

NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983
---	--

(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 5 Class III	A 008		
A 025 SS=G	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, 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 and interview, it was determined the facility failed to provide	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 6 appropriate supervision to meet the needs of a resident and to notify the resident's health care provider after a significant change occurred with the resident, for 1 out of 6 sampled residents. The findings include: During review of the one day adverse incident report dated _____, the major incident report dated _____, the resident observation log note dated _____ and the police report, it was revealed all residents (Resident #1, #2, #3, #4, #5 & #6) residing in the facility were left unattended by Staff #4, on this date at approximately 7:45 PM. Staff #4 walked out to the patio where a fenced pool was and proceeded out of the screened area (off the facility grounds), leaving both of the doors unlocked and the residents unattended in the facility. Sometime before 8:30 PM on _____, a neighbor found Resident #1 walking outside in the rain approximately 3 house down from the facility and attempted to return her to the facility. It was noted the neighbor attempted to return the resident to the facility, upon numerous attempts by knocking on the door no employee responded. At that time the neighbor contacted local law enforcement. They arrived to the facility and attempted to return the resident by knocking on the front door. However, no employee responded. The law enforcement officer, walker around to the rear of the house in which access was granted access to the facility through the patio doors which both doors were left open. Upon entrance to the facility the law enforcement officers noted that 5 additional residents were located in the facility sleeping in their beds. The Administrator was contacted and arrived shortly after and confirmed all 6 residents resided at the facility. Staff #4, subsequently arrived to the facility and was _____ for	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983
---	--

(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 "neglect" and removed from the facility. The Administrator stated during interview at 12 PM on , that she had not contacted Resident#1's health care provider regarding the elopement of resident. Staff #4 leaving 6 adults unattended for unknown timeframe, jeopardized the well-being and safety of the residents residing at the facility. Class II	A 025		
A 026 SS=D	58A-5.0182(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility shall provide an ongoing activities program. The program shall provide diversified individual and group activities in keeping with each resident 's needs, abilities, and interests. (b) The facility shall consult with the residents in selecting, planning, and scheduling activities. The facility shall demonstrate residents ' participation through one or more of the following methods: resident meetings, committees, a resident council, suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities shall be available at least six (6) days a week for a total of not less than twelve (12) hours per week. Watching television shall not be considered an activity for the purpose of meeting the twelve (12) hours per week of scheduled activities unless the television program is a special one-time event of special interest to	A 026		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 026	Continued From page 8 residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required twelve (12) hours per week of scheduled activities. An activities calendar shall be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to three (3) hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure an ongoing activities program was offered and provided to residents at the facility, including their input on selection of activities and demonstration of their participation. The findings include: On _____ at 3 PM, the Administrator was interviewed and stated the activities calendar on the bulletin board was followed but most residents like to read and only participate in some activities. Upon request for documentation from the Administrator of which activities the residents participate in, any notes, suggestions, group discussions or any other form of communication from residents related to activities, she revealed no documentation was available for review. The calendar was reviewed and for _____ 2013, had this day's activities listed as occurring on the 26th of the month rather than the 20th and listed "Game time: Card: Puzzle". The Administrator showed a 500 piece puzzle for residents which was too difficult for them and a children's card game that was not recognized by Resident #5	A 026			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 026	Continued From page 9 when he was interviewed at this time. Subsequently, observations continued until 4:45 PM on this date and again from 8 AM until 3 PM on _____ with none of the scheduled activities taking place. "Walking around the garden" scheduled for _____ at 4 PM did not occur and "Picnic Day" scheduled for _____ was not prepared for by 3 PM on _____. Residents were observed in their beds most of the day, only coming out for meals and some sitting outside with a newspaper. Class III	A 026		
A 030 SS=J	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: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983
---	--

(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 10 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 and 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.	A 030		
-------	---	-------	--	--

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983
---	--

(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 11 (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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 12 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 _____ 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 _____, 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	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 13 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 record review and an interview, the facility failed to provide adequate supervision for 6 out of 6 sampled residents (Resident #1-#6), resulting in neglect of the residents. The findings include: On _____, the record for Resident #1 was reviewed and contained a health assessment (Form 1823) dated _____ that noted Resident #1 had _____ services needed identified by the administrator on _____ included an "alarm system" and "keeping the facility locked" related to "eloping" prior to admission to the facility, and an observation note dated two days after admission on _____ that "she wanted to escape from the ALF" and "was wandering". On or about _____, the resident received a MedicAlert bracelet that included contact information for the resident to be returned to the facility in case she eloped. The toll free number was noted to keep on file a list of her medications, contact information for her daughter, medical conditions, _____ personal identification information, etc.	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 14 On at approximately 7:45 PM, Staff #4 left all 6 of the residents (Resident #1-#6) unattended at the facility. Staff #4 walked out to the patio where a fenced pool was and proceeded out of the screened area (off the facility grounds), leaving both of the doors unlocked and the residents unattended in the facility. Sometime before 8:30 PM on a neighbor found Resident #1 walking outside in the rain approximately 3 house down from the facility and attempted to return her to the facility. It was noted the neighbor attempted to return the resident to the facility, upon numerous attempts by knocking on the door no employee responded. At that time the neighbor contacted local law enforcement. They arrived to the facility and attempted to return the resident by knocking on the front door. However, no employee responded. The law enforcement officer, walker around to the rear of the house in which access was granted access to the facility through the patio doors which both doors were left open. Upon entrance to the facility the law enforcement officers noted that 5 additional residents were located in the facility sleeping in their beds. The Administrator was contacted and arrived shortly after and confirmed all 6 residents resided at the facility. Staff #4, subsequently arrived to the facility and was for "neglect" and removed from the facility. The Administrator stated during interview at 12 PM on that she had not contacted Resident#1's health care provider regarding the elopement of resident. On at 2:15 PM, Resident #1's daughter was interviewed by phone and stated the resident has eloped before from other places and has been moved from approximately 5 different facilities prior to this one. She stated she had not eloped from this facility until now but was	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 15 supposed to be wearing her MedicAlert bracelet. The resident had not had the bracelet on for "maybe a few days" according to the daughter. The Administrator stated during interview at 9:30 AM on _____, that the resident's bracelet slipped off when washing or bathing "a day or two before" and asked the resident's daughter to get links taken out to prevent this from happening. The resident's daughter took the resident on outings almost daily. Staff #1 also explained during interview that the alarm system that was left on before she left the facility on _____ at approximately 7:45 PM would identify the door that was open with a voice and would not have stopped alerting residents or staff when Staff #4 left the facility. During review of Staff #4's personnel file, no criminal background screening could be located. During interview with the Administrator on _____ at 2:30 PM, she acknowledged she had not completed a background screening prior to leaving Staff #3, #4 and #6 alone with residents. At this time, a computer check with our Agency's background screening unit was conducted and showed Staff #4 was "ineligible" at this time to work with _____ adults. Therefore, if these results had been obtained, Staff #4 should not have been working in the facility and providing direct care services to the 6 _____ adults. This is a direct threat to the safety and well being of all residents. Class I	A 030			
A 032 SS-J	58A-5.0182(8) FAC Resident Care - Elopement Standards (8) ELOPEMENT STANDARDS.	A 032			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 032	Continued From page 16 (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision. 1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with _____ and related _____ assessed at high risk. 2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident's family/caregiver. (b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include: 1. An immediate staff search of the facility and premises; 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 032	Continued From page 17 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure residents identified as at risk for elopement had a photo of the resident on file and identification on the resident at all times, to ensure adequate supervision was provided, for 1 out of 6 sampled residents (Resident #1). The findings include: Review of Resident #1's file, revealed a health assessment (Form 1823) dated _____ Resident #1's medical diagnosis (as noted on the health assessment) documented as "services needed" as identified by the Administrator on _____ included an "alarm system" and "keeping the facility locked" related to "eloping" prior to admission to the facility. An observation note dated two days after admission on _____ noted that "she wanted to escape from the ALF" and "was wandering". During an interview with the Administrator on _____ at 10 AM, she revealed on or about _____, the resident received a MedicAlert bracelet that included contact information for the resident to be returned to the facility in case she eloped. The toll free number was noted to keep	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983	
(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 032	Continued From page 18 on file a list of her medications, contact information for her daughter, medical conditions, personal identification information, etc. On _____ at approximately 7:45 PM, Staff #4 left the residents unattended at the facility by exiting out the back door to the patio where there is a fenced pool and out through the screened area, leaving both doors unlocked behind. At approximately 8:20 PM, Resident #1 eloped from the facility and was found by a neighbor. The neighbor attempted to contact anyone in the facility since Staff #4 was gone, numerous attempts made by knocking on the door of the facility but unsuccessful. The neighbor then contacted law enforcement due to unsuccessful attempts to locate an employee at the facility. Law enforcement was able to escort the resident back into the facility safely and the resident's daughter, the Administrator and Staff #1 were subsequently made aware of the elopement. Upon return of Staff #4, he was _____ for "neglect" by local law enforcement. On _____ at 2:15 PM, Resident #1's daughter was interviewed by phone and stated the resident has eloped before from other places and has been _____ from approximately 5 different facilities prior to this one. She stated she had not eloped from this facility until now but was supposed to be wearing her MedicAlert bracelet. The resident had not had the bracelet on for "maybe a few days" according to the daughter. The Administrator stated during interview at 9:30 AM on _____ that the resident's bracelet slipped off when washing or bathing "a day or two before" and asked the resident's daughter to get links taken out to prevent this from happening. The resident's daughter took the resident on outings almost daily.	A 032		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 032	Continued From page 19 Resident#1 was observed at 8 AM on _____ at the facility and was pleasantly _____, following staff and this surveyor around the home, ambulating independently. The identification bracelet was observed on her right wrist. During review of the resident's file on no picture ID that was accessible for staff and law enforcement as necessary could be found. During an interview with the Administrator on _____ at 1 PM, she confirmed the file lacked a photo ID of the resident and that no further information was available for review. During review of Staff #4's personnel file, no criminal background screening could be located. During interview with the Administrator on _____ at 2:30 PM, she acknowledged she had not completed a background screening prior to leaving Staff #3, #4 and #6 alone with residents. At this time, a computer check with our Agency's background screening unit was conducted and showed Staff #4 was "ineligible" at this time to work with _____ adults. Therefore, if these results had been obtained, Staff #4 should not have been working in the facility and providing direct care services to the 6 _____ adults. This is a direct threat to the safety and well being of residents. Class I	A 032		
A 052 SS=D	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 052	Continued From page 20 self-administered medication, either: a nurse; or an unlicensed staff member, who is at least trained 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. (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. (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. (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	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 052	Continued From page 21 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. (c) Administration of medications through intermittent positive pressure breathing machines or a _____ (d) Administration of medications by way of a tube inserted in a cavity of the body. (e) Administration of _____ preparations. (f) Irrigations or debriding agents used in the treatment of a skin condition. (g) _____ or _____ preparations. (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	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 052	Continued From page 22 preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (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. This Statute or Rule is not met as evidenced by: Based on observation, record review and an interview, the facility failed to ensure 4 out of 6 sampled residents (Resident #1, #3, #5 and #6) received assistance with medication without unlicensed personnel using discretion and without error. The findings include: a) On _____ the _____ 2013 Medication Record was reviewed and showed Resident #1 was receiving _____ 15 mg every night at 9 PM. The resident had a diagnosis of _____ and was unable to give an accurate self-report. The Administrator stated during interview at 2 PM on _____ that the resident's doctor had changed the medication to a standing order but she was unable to find an order to indicate this. A phone call was made to the physician's office at 10 AM on _____ and the representative confirmed that the doctor had notes to indicate he was aware the resident was taking the medication every night and stated she was going to contact the facility to send them a copy of a change order from "PRN (as needed)" to "every night". The Administrator (unlicensed) is not permitted to use discretion when providing uninformed residents with "PRN" medications when they are incapable of requesting and understanding the medication.	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED _____
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

MAGDOLNA HOME CARE INC

STREET ADDRESS, CITY, STATE, ZIP CODE

**372 SW TODD AVE
PORT SAINT LUCIE, FL 34983**

(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 052	Continued From page 23 b) Resident #3's health assessment (Form 1823) dated _____ indicated the resident has _____ with hallucinations". The resident's 2013 Medication Record showed the resident had _____ 1 mg, one tablet three times a day as needed/PRN listed without specific parameters for unlicensed personnel to follow. It was documented that the resident received this medication twice on _____ by unlicensed staff. This resident is not capable of requesting the medication fully informed from unlicensed personnel without them using discretion. c) Resident #5 had a diagnosis of _____ and was interviewed at 11 AM on _____ when he stated his back was hurting. The Administrator told the resident he could only have his pain medication every 8 hours. Upon review of the resident's 2013 Medication Record, it showed the resident had no documented medication provided for pain in _____. However, the 2013 Controlled Substance Sheet was completed and showed the resident was taking 1/2 _____ once a day in the morning. The Medication Record showed the resident was prescribed to take 1/2 to a whole tablet up to 3 times a day. This prescription was left for unlicensed personnel to make judgement as to how much and how often Resident #5 was to have his pain medication. d) On _____ at 1:30 PM, Resident #6 requested his eye drops from Staff #1. She dropped 3 separate medications in the resident's eyes and did not wait in between drops. The resident's 2013 Medication Record was reviewed and showed the resident was supposed to receive only 2 of the medications, _____ and _____ at 8 AM (not 1:30 PM). The Administrator called the pharmacy at this time	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 052	Continued From page 24 and confirmed that the resident was no longer supposed to be taking _____ drops (the third medication given to him). Additionally, the directions for use on the eye drop box indicated that there was to be a 10 minute wait between different eye drops, which was not done. The resident was interviewed at this time and stated, "that's not supposed to happen and I was supposed to get them at 8 AM or 9 AM". Class III	A 052		
A 054 SS=D	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 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	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 25 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 an interview, it was determined the facility failed to ensure Medication Observation Records (MORs) were maintained and up-to-date for 1 out of 6 sampled residents, R5. The findings include: Review of Resident #5's health assessment documents a diagnosis of _____. During an interview with Resident #5 at 11 AM on he stated his back was hurting. The Administrator told the resident he could only have his pain medication every 8 hours. Upon review of the resident's 2013 MORs, it indicated the resident had no documented medication provided for pain in _____. However, the 2013 Controlled Substance Sheet was completed and documented the resident was taking 1/2 _____ once a day every day in the morning. During interview with the Administrator at this time, she had no explanation of why the MORs were blank for the month and only the Controlled Substance Sheet was completed. Class III	A 054		
A 056 SS=D	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	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 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 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	A 056			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER

MAGDOLNA HOME CARE INC

STREET ADDRESS, CITY, STATE, ZIP CODE

**372 SW TODD AVE
PORT SAINT LUCIE, FL 34983**

(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 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 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:	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER

MAGDOLNA HOME CARE INC

STREET ADDRESS, CITY, STATE, ZIP CODE

**372 SW TODD AVE
PORT SAINT LUCIE, FL 34983**

(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 Based on record review and an interview, the facility failed to ensure "PRN/as needed" medication had specific parameters for unlicensed personnel to follow for 3 of 6 sampled residents (Resident #1, #3 and #5); and that medications were left in properly labeled containers for 5 out of 6 sampled residents (Resident #1, #2, #4, #5 and #6). The findings include: a) On _____, the _____ 2013 Medication Record was reviewed and showed Resident #1 was receiving _____ 15 mg every night at 9 PM. The resident had a diagnosis of _____ and was unable to give an accurate self-report. The Administrator stated during interview at 2 PM that the resident's doctor had changed the medication to a standing order but she was unable to find an order to indicate this. A phone call was made to the physician's office at 10 AM on _____ and the representative confirmed that the doctor had notes to indicate he was aware the resident was taking the medication every night and stated she was going to contact the facility to send them a copy of a change order from "PRN/as needed" to "every night". The Administrator had provided this resident with a "PRN" medication when the resident was incapable of requesting and understanding the medication prior to receiving the potential new order for the directions of use to change to "every night". b) Resident #3's MORs for month of _____ documented he was to receive _____ 1 mg "PRN/as needed" but did not indicate for what. The resident had a diagnosis of _____ and the facility had unlicensed staff assisting with medication. There were no specific parameters	A 056		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED												
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983														
(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 for this medication to follow for this resident who could not make informed decisions with medication. c) Resident #5 had a diagnosis of _____ and was interviewed at 11 AM on _____ when he stated his back was hurting. The _____ 2013 MORs showed the resident was prescribed to take _____ 1/2 to a whole tablet up to 3 times a day "PRN/as needed". This prescription was left for unlicensed personnel to make judgement as to when the resident was to receive the medication without specific parameters, i.e. for back pain. Finally, while reviewing the medication cabinet with the Administrator at 2:15 PM, Resident #1, #2, #4, #5 and #6s' medications (except Resident #3) were observed in pill boxes. The Administrator stated during interview at this time that she pours the medication into the pill boxes or in souffle cups and allows staff to assist residents afterwards. She was unaware that the medications had to remain in the properly labeled containers, which were present in the cabinet. Class III	A 056															
A 079 SS=D	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: <table border="0"> <tr> <td>Number of Residents</td> <td>Staff Hours/Week</td> </tr> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td>6-15</td> <td>212</td> </tr> <tr> <td>16-25</td> <td>253</td> </tr> <tr> <td>26-35</td> <td>294</td> </tr> <tr> <td>36-45</td> <td>335</td> </tr> </table>	Number of Residents	Staff Hours/Week	0-5	168	6-15	212	16-25	253	26-35	294	36-45	335	A 079			
Number of Residents	Staff Hours/Week																
0-5	168																
6-15	212																
16-25	253																
26-35	294																
36-45	335																

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 079	Continued From page 30 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 residents over 95 add 42 staff hours per week. 2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night. 4. At least one staff member who is trained in First Aid and _____, as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at all times when residents are in the facility. 5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least _____ must be designated in writing to be in charge of the facility. 6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement. 7. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 8. Only on-the-job staff may be counted in	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 079	Continued From page 31 meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident's care. (d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required. 1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 079	Continued From page 32 meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency. 3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined the facility failed to ensure at least one staff member who had access to facility and resident records in case of an emergency was in the facility at all times when residents were in the facility; and, failed to ensure at least one staff member who is trained in First Aid and _____ was in the facility at all times when residents were present.	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 079	Continued From page 33 The findings include: On _____, review of a one day adverse incident report dated _____, a note dated _____ on the resident observation log and an ALF Incident Report dated _____ revealed Staff #4 had left residents alone in the facility on _____ at approximately 7:45 PM without any other staff member present. According to the Administrator, resident records were inaccessible at this time. Additionally, during review of the staff member's personnel file, no documentation of training in First Aid or _____ was present. The Administrator confirmed aforementioned and stated during interview at 12 PM on _____ that she did not have any documentation of training for Staff #4 who was left in sole charge of residents at times. Class III	A 079		
A 081 SS=D	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____, may be used to meet this requirement. (b) Staff who provide direct care to residents	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 081	Continued From page 34 must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED _____
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 081	Continued From page 35 policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure all direct care staff members had received the required in service-training to perform his/her job duties as a Resident Care Aid, for 5 out of 5 sampled staff (Staff #1, #2, #3, #6 and #7), as required. The findings include: On _____ at 12 PM, sampled personnel files were reviewed for required in-service training. The following discrepancies were identified: a) Staff #1-Hired _____ 1) No training in the elopement policy and procedure 2) No elopement drill participation documented 3) No training in the facility's emergency procedures b) Staff #2-Hired _____ (Administrator) 1) No training in the elopement policy and procedures c) Staff #3-Hired _____ 1) No training in the elopement policy and procedure 2) No training in the facility's emergency procedures d) Staff #6-Hired _____ 2012 1) No training in the elopement policy and procedure	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
---	--	--	-------------------------------

NAME OF PROVIDER OR SUPPLIER

MAGDOLNA HOME CARE INC

STREET ADDRESS, CITY, STATE, ZIP CODE

**372 SW TODD AVE
PORT SAINT LUCIE, FL 34983**

(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 081	Continued From page 36 2) No training in the facility's emergency procedures e) Staff #7-Hired _____ 1) No training in the elopement policy and procedure 2) No training in the facility's emergency procedures These findings were discussed with the Administrator at this time, she revealed no further documentation was available for review for these employees. Class III	A 081		
A 084 SS=D	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and	A 084		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 084	Continued From page 37 procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule 58A-5.0185, F.A.C., including: a. Assist with oral dosage forms, _____ dosage forms, and _____ and nasal dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; and g. Recognize the general signs of adverse reactions to medications and report such reactions. (c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 084	Continued From page 38 and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined the facility failed to ensure all employees that provide assistance with self-administered medications had successfully completed a minimum of 2 hours of continuing education training annually on providing assistance with self-administered medications and safe medication practices in an ALF, for 7 out of 7 sampled unlicensed staff (Staff #1, #2, #3, #5, #6, #7 & #8). The findings include: The personnel files for Staff #1-#3 and #5-#8 were reviewed for documentation of a minimum of 2 hours of continuing education completed annually on providing assistance with self-administered medications and safe medication practices in an ALF. Review of the personnel files, revealed there was no documentation of this training dated within the previous year for these unlicensed staff (Resident Care Aides) who provided assistance with self-administration of medication to residents. The Administrator was interviewed at approximately 3:30 PM on _____ and confirmed that the documentation was not present and available for review for any of these staff who assisted residents with medication by either handing them soufflé cups with their pills or by placing eye drops in a resident's eyes.	A 084			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 084	Continued From page 39 Class III	A 084		
A 086 SS=D	58A-5.0191(9) FAC Training - ADRD (9) _____'S _____ AND RELATED _____ ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 434.4.6 of the Florida Building Code, as adopted in Rule 9N-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who have regular contact with or provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between _____ 1998 and _____ 2003 shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection will be considered as having met this requirement. "Staff who have regular contact" means staff who interact on a daily basis with residents but do not provide direct care to residents. Initial training, entitled "_____'s _____ and Related _____ Level I Training," must address the following subject areas: 1. Understanding _____ and related 2. Characteristics of _____ 3. Communicating with residents with _____ s 4. Family issues; 5. Resident environment; and 6. Ethical issues. (b) Staff who have received both the initial one hour and continuing three hours of ADRD training pursuant to Sections 400.1755, 429.917, and 400.6045(1), F.S., shall be considered to have	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 086	Continued From page 40 met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these 1. Behavior management; 2. Assistance with ADLs; 3. Activities for residents; 4. Stress management for the care giver; and 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection can be found in the document " Training Guidelines for the Special Care of Persons with and Related " dated 1999, incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under Section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by Section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on	A 086			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 086	Continued From page 41 interacting with such residents, as required under Section 429.178, F.S., within three (3) months of employment. " Incidental contact " means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor ' s degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with ' s or related or 2. Three years of practical experience in a program providing care to persons with ' s or related or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with ' s or related (h) With reference to requirements in paragraph (g), a Master ' s degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor ' s degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and an interview, the facility failed to ensure that 3 out of 3 sampled staff (Staff #1, #2, and #8) who have regular contact with or provide direct care to residents with ADRD and Related had obtained 4 hours of initial training (ADRD Level 1) within 3 months of employment;	A 086		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 086	Continued From page 42 4 hours of continuing education within 9 months of hire (ADRD Level II) and 4 hours of annual update training in ADRD. The findings include: The personnel files for Staff #1, #2, and #8 were reviewed for training in ADRD. It was noted the files did not contain documentation of this training dated within the required timeframes. The following training was documented after the date of hire for these employees: a) Staff #1-Date of Hire _____ 1) Training certificate was dated _____, no training within 3 months of hire b) Staff #2-Date of Hire _____ (opening/Administrator) 1) No Level I or Level II training certificates available for review. c) Staff #8-Date of Hire _____ (opening/Administrator's mother) No Level I or Level II training certificates available for review. These findings were discussed during interview with the Administrator at approximately 3 PM on _____. She confirmed that the facility keeps the doors locked at all times to secure R#1 and also advertises in their brochure, "Secured Unit". Class III	A 086			
A 160 SS=D	58A-5.024(1) FAC Records - Facility Records. The facility shall maintain the following written	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 160	Continued From page 43 records in a form, place and system ordinarily employed in good business practice and accessible to Department of Elder Affairs and Agency staff. (1) FACILITY RECORDS. Facility records shall include: (a) The facility's license which shall be displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the place from which the resident was admitted, and if applicable, a notation the resident was admitted with a pressure and 2. Date of discharge, the reason for discharge, and the identification of the facility to which the resident is discharged or home address, or if the person is the date of Readmission of a resident to the facility after discharge requires a new entry. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intends to return pursuant to Rule 58A-5.025, F.A.C. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) An up-to-date record of major incidents occurring within the last 2 years. Such record shall contain a clear description of each incident; the time, place, names of individuals involved; witnesses; nature of injuries; cause if known; action taken; a description of medical or other services provided; by whom such services were provided; and any steps taken to prevent recurrence. These reports shall be made by the individuals having first hand knowledge of the	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 160	Continued From page 44 incidents, including paid staff, volunteer staff, emergency and temporary staff, and student interns. (e) The facility ' s emergency management plan, with documentation of review and approval by the county emergency management agency, as described under Rule 58A-5.026, F.A.C., which shall be located where immediate access by facility staff is assured. (f) Documentation of radon testing conducted pursuant to Rule 58A-5.023, F.A.C.; (g) The facility ' s liability insurance policy required under Rule 58A-5.021, F.A.C.; (h) For facilities which have a surety bond, a copy of the surety bond currently in effect as required by Rule 58A-5.021, F.A.C. (i) The admission package presented to new or prospective residents (less the resident ' s contract) described in Rule 58A-5.0182, F.A.C. (j) If the facility advertises that it provides special care for persons with _____ or related _____, a copy of all such facility advertisements as required by Section 429.177, F.S. (k) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 58A-5.0182, F.A.C. (l) All food service records required under Rule 58A-5.020, F.A.C., including menus planned and served; county health department inspection reports; and for facilities which contract for catered food services, a copy of the contract for catered services and the caterer ' s license or certificate to operate. (m) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., issued within the last two (2) years.	A 160			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 160	Continued From page 45 (n) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (o) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (p) Additional facility 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. (q) The facility's resident elopement response policies and procedures. (r) The facility's documented resident elopement response drills. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined the facility failed to ensure at least 2 elopement response drills were conducted every year and included all staff for at least one drill. The findings include: On _____, the documented elopement response drills were requested from the Administrator during interview at approximately 1 PM. The last documented "mock drill" was dated _____ 2012. There were no subsequent drills documented other than the actual elopement that occurred on _____. The absence of a second drill in 2012 as required did not allow newly hired staff to participate, specifically Staff #1 and #6 who were hired in 2012.		A 160		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 160	Continued From page 46 Class III	A 160			
A 165 SS=D	429.23 FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report Internal risk management and quality assurance program; adverse incidents and reporting requirements. - (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, " adverse incident " means: (a) An event over which facility personnel could exercise control rather than as a result of the resident ' s condition and results in: 1. _____ 2. _____ or spinal damage; 3. Permanent _____ 4. _____ or _____ of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury.	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 165	Continued From page 47 (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or : must be reported to the Department of Children and Family Services as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 165	Continued From page 48 by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within one (1) business day after the incident on AHCA Form 3180-1024, Assisted Living Facility Initial Adverse Incident Report-1 Day, _____, 2006, and incorporated by reference. The form shall be submitted via electronic mail to riskmgmt@ahca.myflorida.com; on-line at http://ahca.myflorida.com/reporting/index.shtml; by facsimile to (850)922-2217; or by U.S. Mail to AHCA, Florida Center for Health Information and Policy Analysis, 2727 Mahan Drive, Mail Stop 16, Tallahassee, Florida 32308-5403, telephone (850)412-3731. AHCA Form 3180-1024 is available from the Florida Center for Health Information and Policy Analysis at the address stated above. The Initial Adverse Incident Report is in addition to, and does not replace, other reporting requirements specified in Florida Statutes. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported under subsection (1) above, the facility shall submit a full report within fifteen (15) days of the incident. The full report shall be submitted on AHCA Form 3180-1025, Assisted Living Facility Full Adverse	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 165	Continued From page 49 Incident Report-15 Day, dated 2006, and incorporated by reference. The methods for obtaining and submitting the form are set forth in subsection (1) of this rule. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined the facility failed to ensure a one day adverse incident report was completed and submitted to the Agency within one business day of an adverse incident occurrence, as required. The findings include: On , the Administrator was interviewed at 11 AM and asked for the adverse incident report related to a resident eloping on due lack of supervision and regarding Employee #4 leaving 6 vulnerable resident (Resident #1, #2, #3, #4, #5 and #6) unattended for unspecified period of time. Review of the report revealed, it did not contain the resident's information, did not mark that the event included allegations of "neglect" or that it was an "event reported to law enforcement" and did not have documented the status of the facility's investigation of the incident. Review of the police report for noted incident on revealed Staff #4 was for "neglect" immediately after the resident was found on the adverse incident report did not indicate this. Additionally, the Administrator stated the report had not been submitted to the Agency within one business day as required "because they don't take faxes" and later stated "they won't take it because the resident wasn't hurt when she eloped". She was unable to provide a contact person for the Agency to	A 165			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MAGDOLNA HOME CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 372 SW TODD AVE PORT SAINT LUCIE, FL 34983		
(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 165	Continued From page 50 confirm she was instructed to refrain from sending in the adverse report, including a one day and 15 day "full report". Class III	A 165			

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Magdolna Home Care Inc.
372 SW Todd Ave.
Port Saint Lucie, FL 34983

RE: CCR #2012018577

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2013 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 2013 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,


for Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

