STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911189	07/24/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Taylor Home	3937 Spring Park Road Jacksonville, FL 32207	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (otc) Products S-S= D
St - A - E210 - 58a-5.0191(7) Fac - Ecc - Training S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced licensure complaint survey, CCR # 2013005255, and a Extended Congregate Care survey was conducted on 2013. Taylor Home had deficiencies found at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and staff interview, the facility failed to notify the family of a resident who was transferred to the hospital for 1 of 3 sampled residents, Resident #1.

The findings include:

A review of the residents record revealed Resident #1 was admitted to the facility on with a diagnosis of severe and her daughter who was the legal health care surrogate and power of attorney, signed the admission paperwork as the responsible party.

Resident #1 had a Certificate of Professional Initiating Involuntary Exam (Baker-Act) on by a Clinical Social Worker. It revealed the resident had and was endangering herself and others, running away and climbing fences. She was increasingly combative, agitated, and She was also making threats against peers and staff.

The nurses' note dated and timed 4:15 p.m. read a representative from the hospital arrived at the facility to evaluate the resident for behavior. The resident continued to show unstable behavior while the representative was conducting the evaluation. At 5 p.m, the transport company arrived and transferred the resident to the hospital for further treatment.

The resident record did not have documentation that the resident's health care surrogate (daughter) was notified of this significant change and transfer out to the hospital.

Employee #2, a licensed practical nurse was interviewed on at 10:44 a.m. She reviewed the resident record and could not find documentation that the resident's daughter was notified of the resident's Baker-act.

Class III

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0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation, record review, and staff and resident interview, the facility failed to properly assist with self administration of medications for 3 of 3 sampled residents, Residents #2, #3, and #4.

The findings include:

Employee #1, a lead Certified Nursing Assistant (non-licensed) was observed to provide medication assistantance to three residents, Residents #2, #3, and #4 on [redacted] at 8:45 a.m. She had just got to the facility to fill in for someone who had called off of work and was starting medication pass. She stated all three residents needed assistance with medication administration.

Employee #1 started with Resident #2. She transferred the 5 pills to a medicine cup and then told the surveyor that the resident had an additional medication order that morning for [redacted] 100 mg. However she stated she did not prepare that medication because the instructions on the Medication Observation Record (MOR) read to give it before her meal. She stated Resident #2 already had her breakfast. She was not sure what to do, so she would have to confer with the nurse on staff. She stated someone would have to call the doctor and ask him what to do. Employee #1 then brought the medication cup into the resident's [redacted] placed the medication cup on the resident's seat of her walker. The resident took one pill at a time. Employee #1 did not explain to the resident what the medications were.

Employee #1 then went to assist Resident #3 with his morning medications. Employee #1 had a hard time finding the medications. She opened up one drawer and then the other. She eventually found the four pills ordered and placed them in a medication cup. There was another order for Bayer [redacted] 81 mg on the Medication Observation Record and it was an over the counter medication(OTC) located in the resident's bin. Employee #1 could not find the resident's name on it. Since it could not be identified as that resident's medication, Employee#1 did not prepare the medication. She stated she would have to get another bottle. In addition, Employee #1 could not find the [redacted] cream ordered for the resident's penis. When she brought the other medications in the resident's [redacted] the employee asked him if he had the cream in his [redacted]. He stated he had it in the [redacted] the medicine cabinet. When Employee #1 looked into the medication cabinet, she could only find a plastic medicine cup with some white cream in it. There was no tube of cream with the prescription label on it for the resident found anywhere in the resident's [redacted] Also in the resident's [redacted], there was a total of 6 medicine cups with white cream in it. Two of them had the cream smeared and was not as full as the other 4. Employee #1 did not explain to the resident what medications she was assisting him with.

The Resident was interviewed on [redacted] at 9:07 a.m. He stated that he never had the tube of the cream, staff brought the medicine to him in those little cups. He stated that his penis was red and [redacted] and he was able to put the cream on by himself and did not need staff to put it on for him. However, he was unaware that there was 4 extra doses of the [redacted] cream in his [redacted] could not explain why he did not use them. Employee #1 could not explain what happened to the actual cream tube or why there was additional medication left in the resident's [redacted].

Employee #1 then assisted Resident #4 with her medications. She prepared the medications at the medication cart and placed them in the medicine cup. There was an order for an OTC of [redacted] 81 mg [redacted]

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Employee #1 could not find the resident's name on it so she did not prepare if for th resident. Employee #1 brought the medications in resident's handed her the cup. She only explained what two of the five medications were to the resident. She explained the because the resident told her she had back and leg pain. She also explained the Viactin because it was a chewable medication and gave those specific instructions.

On at 9:25 a.m,, Employee #1 was interviewed about her medication assistance technique for medication assistance. She confirmed that she did not explain to the residents what medications she was assisting with.

Class III

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC

Based on observation, record review, and staff interview, the facility failed to have over the counter (OTC) medications properly labeled for 2 of 3 sampled residents observed for medication assistance, Residents # 3 and #4.

The findings include:

Employee #1, a lead Certified Nursing Assistant (non-licensed) was observed to provide medication assistance to two residents, Residents , #3, and #4 on at 9 a.m.

Employee #1 went to assist Resident #3 with his morning medications. Employee #1 had a hard time finding the medications. She opened up one drawer and then the other. She eventually found the four pills ordered and placed them in a medication cup. There was another order for Bayer 81 mg on the Medication Observation Record and it was an over the counter medication(OTC) located in the resident's bin. Employee #1 could not find the resident's name on it. Since it could not be identified as that resident's medication, Employee #1 did not prepare the medication. She stated she would have to get another bottle.

Employee #1 then assisted Resident #4 with her medications. She prepared the medications at the medication cart and placed them in the medicine cup. There was an order for an OTC of 81 mg Employee #1 could not find the resident's name on it so she did not prepare if for th resident.

Class III

E210-ECC - Training 58A-5.0191(7) FAC

Based on record review and staff interview, the facility failed to provide documentation of Extended Congregate Care (ECC) training for the ECC Supervisor and all facility staff.

The findings include:

The facility was asked to provide documentation of the ECC training for the Supervisor and facility staff. The

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Director of Nurses(DON) on [redacted] at 12:58 pm stated that the Administrator was now the ECC Supervisor (since the ALF Supervisor left last month) and he was not available this week. Since he was the one who did the all of the training, this paperwork was somewhere in his office. The DON stated she turned the administrator's office upside down and could not find ECC training for him or the employees.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Taylor Home
3937 Spring Park Road
Jacksonville, FL 32207

Re: CCR #2013005255

Dear Administrator:

This letter reports the findings of a state licensure complaint survey and a Extended Congregate Care survey that was conducted on 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) 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 surveyor. Should you have any questions please call this office at

Sincerely,

Keisha Woods

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KW/sm
Enclosure