STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968046	07/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myrtice Angels Senior Home Care Llc	**2570 Vernon St Jacksonville, FL 32209**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin
St - A - 0084 - 58a-5.0191(5) Fac - Training - Assis Self-Admin Meds & Med Mgmt S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= D

Specific Tag Findings:

0000-Initial Comments

A Limited Nursing Service Survey was conducted on , 2013.
Mytrice Angels Senior Home LLC had Licensure deficiencies found at the time of the visit.

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC

Based on record review and staff interview, the facility failed to assess a resident for elopement risk and implement an elopement policy for 1 of 6 sampled residents, Resident #1.

The findings include:

Resident #1 was observed on at 11:20 a.m. sitting outside on the front porch. He had on a long sleeve shirt and sweater on. It was the middle of the summer and very warm outside.

Resident #1's record was reviewed. His 11-16 health assessment revealed a diagnosis of with mental status changes and memory loss. Further review of the record revealed three forms from of the office of the Sheriff for the City of Jacksonville dated and another date that could not be read clearly. On these forms "missing persons" was initialed by the officer.

There were several resident observation notes revealing the resident had continuing memory and behavior problems:

Resident still be runaway from the facility time to time and the staff have to go and bring him back.
Resident still had problems remembering and he got lost coming back from church and a police officer had to bring him home.
Resident was refusing to take medications and take a bath for two days. The staff member called his wife 4 times with no answer. The staff member called rescue for two days and a C/T officer. The staff member had to call an evaluator to come out and they heard him in the background being loud and rude.

The Administrator on at 1:30 pm was asked to explain this last entry on She stated that the resident continued to have behavioral problems by talking loudly and refusing to pay his rent. On she

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had to call an evaluator from the hospital because they have qualified staff who could baker-act residents. The police would not do anything. They came and baker-acted him. He returned to the facility on . She stated that she did not consider Resident #1 at risk for elopement because he was returned within 24 hours. She did not have a picture of him and did not implement her elopement policy and procedure. She confirmed she did not have the baker-act paperwork and did not document in the resident's record the full incident that occurred. She also did not notify any family member. She did not know at the time that the resident was leaving sometimes to see his wife, but his wife did not want him to. Resident #1 was not allowed to see her.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on record review and staff interview, the facility failed to properly assist with medication administration and properly maintain medication Observation Records (MOR) for 2 of 2 sampled residents, Residents #1 and #2.

The findings include:

Resident #1 had a health assessment with diagnoses of controlled with medication and rule out This health assessment listed two medications 3 mg at bedtime and per sliding scale 3 main meals. These were not on his current Medication Observation Record (MOR) and these were not in his medication bin. There was another medication, 30 mg (an in the medication bin that was empty. The resident's 2013 MOR revealed an "X" on the 22nd at 7p.m for the The MOR did not explain what the X meant.

The Administrator on at 12:44 p.m. confirmed these two medications were not in his medication bin. She stated she must have overlooked them. She did not call the doctor to clarify these medications to see if he was to have sugar checks with sliding scale to manage his three times a day. The Administrator stated that the "X" for the meant they did not have it. They ran out of it.

Resident #2 moved into the facility on 2013. He did not have a health assessment yet. However he did come in with medications and a MOR was completed for him. The MOR revealed discrepancies for several medications :

81 mg one daily at 7 a.m.
1 mg daily at 7 a.m
25 mg twice daily as needed (no indication for use) scheduled for 7 a.m and 7 p.m.

The was not signed for on
The had "X"'s on the 20th, 21st, 22nd, and 23rd of 2013 (it was not given)

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The had "X"s on the 20th at 7 pm, on the 21st for both 7 a.m and 7 pm, on the 22nd for both 7 am and 7 pm, and on the 7 a.m on the 23rd. was used for itching)

Resident #2 had a bottle of Polyethylene in his medication bin with directions for take one capful by mouth each day for . Take mixed in 4 to 8 ounces of water, juice, soda, coffee, or tea. This medication was not the MOR.

The Administrator was interviewed on at 1:45 p.m. She stated that they ran out of the and The resident got his medications through the Veterans Administration (VA) and that can take a long time. She was asked if she called yet to get the refill. She had not. She stated that the employee this morning probably just forgot to sign for the The Administrator could not explain why the Polyethlene was not on the MOR and was not being given. She stated the resident had a VA appointment last week and she stated he probably forgot to ask for refills.

Resident #2 was interviewed on at 2 p.m. He stated he still had an itchy back. He had a on his back when he went into the hospital. That was what the medication was for. He stated he did not ask for any medication. The staff just gave him his medications. He was not sure what medications he took. He was not sure when his VA appointments were for or how he got there.

Class III

0084-Training - Assis Self-Admin Meds & Med Mgmt 58A-5.0191(5) FAC

Based on record review and staff interview, the facility failed to ensure that 1 of 3 sampled employees, Employee #1 had the intital 4 hour medication training.

The findings include:

Employee #1 on at 11:35 a.m. was asked if he assisted with medication administration. He replied yes. He was asked for his training documentation. He looked through a file cabinet and could not find it. He stated when the Adminstrator arrived, she would have to find it.

The Administrator arrived at the facility around noon. She stated E#1 did assist with medication assistance and she could not find his training documentation.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on observation, record review, and staff and resident interview, the facility failed to follow the scheduled menu for lunch and dinner .

The findings include:

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On [redacted] at 11:20 a.m., Employee #1 was asked what he was serving the residents for lunch. He stated he was making hotdogs and fruit. He stated he was making chicken for dinner and was defrosting it now in the refrigerator. He stated there was a menu but he didn 't follow it. He used to follow it but stopped doing it over the weekend.

Resident #1 was interviewed on [redacted] at 11:45 a.m. He stated he did not eat good here. All they have was corn flakes in the morning and sometimes boiled eggs. He stated they always cook hot dogs here. He stated the other guy who used to work here really fed us badly. Employee #1 had only been here a few weeks and he can only give us what the Administrator gave him to cook. He stated when he was a taxi cab driver he was 160 [redacted] Now he was 135 lbs. His most recent health assessment dated [redacted] reveald a weight of 123 lbs.

The menu was posted above the stove. The menu stated Lafeta's Family Home Care Week 4. Employee #1 was not sure what week they were on. Week four for lunch was peanut butter and jelly sandwhich.

The Administrator arrived around noon and Employee #1 left the facility. The Administrator stated she was on the 3rd week of the Menu. She was asked to read the menu for Tuesday. The Administrator read for lunch peanut butter and jelly and for dinner pepper steak. She confirmed that she did not follow the menu today and she served hot dogs for lunch. She stated she did have peanut butter and jelly and just did not serve it. She stated she did also have the pepper steak. The Administrator showed the surveyor ground beef and she stated she put pepper on it. She did not know why Employee #1 did not follow the menu.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on record review and staff interview, the facility failed to report elopements as adverse incidents for 1 of 6 sampled residents, Resident #1.

The findings include:

Resident #1 was observed on [redacted] at 11:20 a.m. sitting outside on the front porch. He had on a long sleeve shirt and sweater on. It was the middle of the summer and very warm outside.

Resident #1's record was reviewed. His 11-16 [redacted] health assessment revealed a diagnosis of [redacted] with mental status changes and memory loss. Further review of the record revealed three forms from of the office of the Sheriff for the City of Jacksonville dated [redacted] and another date that could not be read clearly. On these forms "missing persons" was initialed by the officer.

There were two resident observation notes revealing the resident would leave the facility without staff knowledge:

[redacted] Resident still be runaway from the facility time to time and the staff have to go and bring him back.
[redacted] Resident still had problems remembering and he got lost coming back from church and a police officer had to bring him home.

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The Administrator on [redacted] at 1:30 pm was interviewed regarding this resident. She stated the resident was baker-acted on [redacted] and returned on [redacted] He returned with an additional diagnosis of [redacted] rule out [redacted]

She stated that she did not consider Resident #1 at risk for elopement every time he left because he was returned within 24 hours. She did not have a picture of him and did not implement her elopement policy and procedure. She did not know at the time that the resident was leaving sometimes he was going to see his wife but his wife did not want him to. Resident #1 was not allowed to see her. She stated she did not evaluate him for elopement even after he returned after his baker-act. She stated she did not complete an adverse incident report and submit it as required.

Class III

0167-Resident Contracts 58A-5.025(1) FAC

Based on record review and staff interview, the facility failed to have an accurate contract for 1 of 6 sampled residents, resident #1.

The findings include:

Resident #1 had a [redacted] residential lease contract signed by the resident and Administrator. The contract revealed the tenant would pay $1200 per month. The Resident's Social Security Statement revealed he only received $1,019.40 monthly.

The Administrator was interviewed on [redacted] at 12:40 pm. She was asked how much he actually paid. She stated he only had his social security. He did not pay $1,200 per month. She confirmed the contract was not correct.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Myrtice Angels Senior Home Care, LLC
2570 Vernon Street
Jacksonville, FL 32209

Dear Administrator:

This letter reports the findings of a state licensure Limited Nursing Services survey that was conducted on 23, 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

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