AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Wiley Retirement Home
Administrator
6561 San Juan Road
Jacksonville, FL 32210

CCR #2013005735

Dear Administrator,

This letter reports the findings of a licensure complaint survey with Limited Nursing Services conducted on 25, 2013, by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

The inspection resulted in findings of non-compliance in the following areas and others not specified in this letter:

1. Due to deficient practice cited at:
A-0007 – Admissions – Criteria - Class II
A-008 – Admissions – Health Assessment – Class III
A-0077 – Staffing Standards – Administrator – Class II

The administrator is to thoroughly review the resident's medical condition, history and physical, psychosocial history, acquire information about familial support, and obtain clarification of any and all physician's orders within 24 hours of a resident being admitted to the facility. The administrator is to develop and implement a plan of care based upon the resident's needs identified through the review of the resident's current condition, and place it in the resident's record. The facility must develop a written policy and procedure specifying how medications and adaptive equipment or supplies will be obtained within 24 hours of a resident's admission. The policy must address how the facility will obtain an emergency supply, and bill the resident/resident's representative if a resident's family/representative does not provide the medications/supplies/equipment within 24 hours of the resident's admission. This policy must be provided to all new residents/residents' representatives with acknowledgement of receipt retained in the resident's medical record.

2. Due to deficient practice cited at:
A-0025 – Resident Care – Supervision – Class II
A-0028 – Resident Care – Activities of Daily Living - Class III
A-0079 – Staffing Standards – Levels – Class III
AZ-815 – Background Screening - Unclassified

The facility is to hire additional staff immediately to assist with supervision of . . . residents during dining,

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2727 Mahan Drive
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as well as, assist with activities of daily living. The facility is to develop and implement a written staffing schedule that addresses how direct care staff will be deployed to meet the needs of the residents on a 24 hour basis, to include scheduled staggered breaks for staff, so that at least two staff (not including housekeepers, cooks or staff passing medications) are on hand at all times to tend to the residents' scheduled and unscheduled service needs. The facility is to ensure eligible background screenings results are obtained and required trainings are completed by staff before they are to work in the facility and interact with the residents.

3. Due to deficient practice cited directly relating to your facility's medication practices cited at:

A- 0051 - Medication – Pill Organizers – Class II
A-0053 – Medication – Administration – Class II
A-0054 – Medication – Records – Class III
A-0055 – Medication – Storage and Disposal – Class III
A-0056 – Medication – Labeling and Orders – Class II
A-0057 - Medication – Over the Counter Products – Class III

The facility is to hire a licensed nurse immediately to assist with sugar monitoring, administration and storage for residents who are unable to perform this task on their own.

The facility must immediately stop the practice of pre-filling syringes and placing them in the storage container for later use by unlicensed staff.

The facility must employ, on staff or by contract, the services of a pharmacist licensed pursuant to Section 465.0125, F.S., or a registered nurse to conduct in-service training including topics: accurate completion of Medication Observation Records; documenting appropriately when residents experience changes in condition, storage and labeling medications correctly, including over the counter medications, maintaining a pill organizer for residents who are capable of self-administration of medications as determined by their health care provider, assisting with "as needed" or "prn" medications, and routine medications, and the provision of care to ependent and responsibilities of reporting to physician abnormal sugars, and changes in condition.

The facility must ensure all unlicensed staff providing assistance with self-administered medications complete a minimum of 2 hours of continuing education training on providing assistance with self-administration of medications. The consultant must use the training course approved by the Department of Elder Affairs that is posted on their website at http://elderaffairs.state.fl.us/doea/pubs/pubs/2012Med_Guide.pdf. All unlicensed staff must complete this training no later than 2013.

The Administrator is to ensure that unlicensed staff can perform these duties correctly by performing weekly audits observing staff while performing this duty for a minimum of 4 weeks and documenting the results of the audits.

The facility shall provide the Agency with, at a minimum, monthly on-site corrective action plan updates until the agency determines after written notification by the consultant and facility administrator that deficiencies are corrected and staff has been trained to ensure that proper medication standards are followed and that such consultant services are no longer required.

The initial on-site consultant visit shall take place within 7 working days of the identification of a Class II deficiency. You must provide the agency a copy of the pharmacist's or registered nurse's license and a signed and dated recommended corrective action plan no later than 10 working days subsequent to the initial on-site consultant visit.

4. Due to deficient practice cited at A-0030 – Resident Rights - Class III
The facility is to ensure that physical [redacted] are limited to the use of ½ bedrails that have been ordered by the resident's physician, and the physician must review the order every 6 months.

Nothing in this Directed Plan of Correction limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

A recommendation for sanctions has been forwarded to Central Office in Tallahassee. This action, if taken, will be a matter of separate correspondence. All deficiencies must be corrected by [redacted], 2013.

Should you have any questions, please call [redacted] Keisha Woods, Health Facility Evaluator Supervisor, at 904-798-4516.

Sincerely,

Keisha Woods

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

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968314	07/25/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Wiley Retirement Home	7024 Wiley Rd Jacksonville, FL 32210	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= G
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0051 - 58a-5.0185(2) Fac - Medication - Pill Organizers S-S= G
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= G
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= G
St - A - 0057 - 58a-5.0185(8) Fac - Medication - Over The Counter (otc) Products S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= G
St - A - 0079 - 58a-5.019(4) Fac - Staffing Standards - Levels S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments

An unannounced licensure complaint survey, CCR# 2013005735, and a Limited Nursing Services survey was conducted on , 2013.

Wiley Retirement Home had deficiencies, including several class II deficiencies, found at the time of the visit. A Directed Plan of Correction was included with the statement of deficiencies.

0007-Admissions - Criteria 58A-5.0181(1) FAC
Based on observation, record review, and staff and resident interview, the facility failed to ensure that a resident was appropriate for admission to the assisted living facility and that the facility was capable of providing the care and services the resident needed for Resident #8, 1 of 12 sampled residents.

The findings include:

On at 2:25 p.m. Resident #8 was observed lying in her bed and was asking for assistance turning in bed. She asked for the surveyor to speak loudly because she needed new batteries for her hearing aid. She stated she would ask the Administrator, but she was too busy. The resident's legs had +2 (and she stated she had hose (anti-embolic stockings) and wore them at home, but had not had any recently. She stated her legs had been like this for a long time. She stated that she had not had any medications since she gotten to the facility.

Resident #8 was admitted on . She had a health assessment, dated ,revealing a medical history and diagnoses of , Hyperkalemia, Acute Failure, Acidosis, Right Hip Repair,

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Type II, and She was alert and oriented x 3. service requirements were It also revealed the resident needed assistance with self administration of medications. Her medication list was for 10 milligrams (mg) daily, 20 mg twice a day, 10 mg daily, 500 mg at hour of sleep, 81 mg daily, 10 mg at bedtime, 10 0mg daily, FeS04 325 mg daily, 5 mg daily, and 1000 mg twice daily.

The Resident had discharge instructions from the nursing facility she transferred from. It listed Hose on in a.m. and off at bedtime. It also listed sliding scale

The Administrator was interviewed on at 3:25 p.m. She stated the resident only got there two days ago. She did not have any medications yet. The nephew was supposed to bring them. She did not have a Medication Observation Record filled out yet either. She stated she had been giving some of the medications to the resident. A few of them were sent over from the other facility. She was asked to see the medications that she gave. She could not find them at the time of the survey. She was asked if the resident was getting her sugars checked. She stated yes that she was doing them (the Administrator was a nurse). She was asked to see the resident's glucometer sugar testing machine) and she stated the Resident did not have one. She was asked how she was performing the sugar checks then. She stated she used either Resident #1's or #11's glucometer. She was asked how she the glucometer between the residents. She stated with She stated she thought it was good enough to clean it with She stated she did not document the glucose readings. She stated she was unsure how many times a day to test her sugar or if she needed per sliding scale. She also was not sure if the resident needed hose or not. She stated she did not have the time yet to call the doctor and clarify the discharge orders. She stated she had to go to the pharmacy across town to get her prescriptions by 6 p.m. As of 5 p.m., the Administrator was still at the facility serving dinner to the residents. The Administrator stated that if she could not get the resident's medications she would send her to the Emergency

Class II

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on observation, record review, and staff interview, the facility failed to have an accurate health assessment for 2 of 2 sampled residents, Residents # 1 and #11.

The findings include:

1. Resident #1 was admitted to the facility on He did not have a new health assessment and there was only an old one on the resident's record dated 2013. It revealed a diagnosis of and short term memory loss. Under the section "Does the individual need help with taking his or her own medicaitons" it was blank. Under additional comments/ observations it listed Lantus 100 units/ml inject 30 units at bedtime and medication reminders only. On page 5 of this document dated it revealed to assist with medications and self administer of and supervise of sugar checks. The Resident's Medication Observation Record (MOR) for 2013 revealed the resident was to have NPH 15 units two times a day at 7 am and 4 p.m.

The Resident was interviewed on 8:36 a.m. He stated that he was on but was not sure of the specific type. He stated his sugar was 135 that morning The Administrator brought over the resident's

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MOR and his medication bin. He was asked to pick out his and draw it up. The resident picked out R and stated he would draw up 8 units. The Administrator (who was nurse) was present and told the resident ," no, this was not the right She handed him the NPH and instructed him to draw up 15 units. The Resident stated the NPH was not right, that it was too strong. The resident stated he did not think he had taken his today.

The family member of Resident #1, the daughter-in-law was interviewed over the telephone on at 10:27 a.m. She stated Resident #1 had lived with her and her husband for a long time. He could do his own sugar testing, but his memory was so bad, she would not trust him to give himself the She would not trust him with the dosages especially. The family member was not aware that the resident was not being supervised with his and that his health assessment read he could do it himself.

2. Resident #11 had a health assessment dated that revealed a medical history of high , forgetful, and special precautions for elopement. Under the section "Does the individual need help with taking his or medications" it was left blank. Under section 3 "services provided to the resident" it listed supervision with medications. A review of the resident's 2013 MOR revealed Easy Max test strips, sugars three times a day at 9 am, 1 pm, and 5 pm. It also revealed Lantus inject 15 units at bedtime at 9 pm.

Resident #11 was interviewed on at 4:09 p.m. He stated that the girls (referring to unlicensed staff) did his sugar testing at night and then they gave him the He stated he did not remember giving himself any injections. The Administrator was present and kept telling the resident, "we do not give you the injection, you do it for yourself". The resident kept responding that the girls did it.

On at 4:10 p.m. , Resident #11 was asked to demonstrate how he tested his own sugar levels. He stated the girls did it. He attempted to do it himself four times unsuccessfully. He kept asking questions about what to do. The Administrator had placed the lancet in his hand and told him to stick his finger. The first two times the resident put the lancet to his skin, he did not break the skin. Then the Administrator took the cap off of the lancet and instructed the resident to stick his skin with the needle sticking out and was obtained. Then the resident tried to put the on the test strip and a small amount was on it, but the machine gave an error message. The Administrator gave up at that point of trying to let him do it himself, and she did the sugar testing for him.

Employee #4 on at 4:22 p.m. was interviewed. She stated that sometimes Resident #11 was not able to do his own sugar testing so Employee #2 did it for him. Employee #2 was an unlicensed staff member.

Both health assessments for Resident #1 and #11 read the residents could accurately and consistently monitor their sugar levels and inject the The observation and interviews by the surveyor revealed neither resident could. Employee #4 confirmed this also.

Class III

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0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on observation, record review, and staff and resident interview, the facility failed to supervise and assist with activities of daily living for residents, Residents #3 , #4, #5, #12, and #7 (for dining , ambulation, transferring) placing them at risk for harm. The facility also failed to supervise another resident, Resident #9 who had a and sustained a laceration to her forehead. The Administrator failed to immediately notify the resident's physician after the to seek additional health care services if warranted.

The findings include:

1. On at 8:15 a.m, three residents were sitting at the table in the corner of the . Residents # 3, #4, and #5. Resident #5 was heard to yell "stop it". The surveyor went over to the table and Resident #5 stated that Resident #3 was messing with Resident # 4's food. Resident #3 had a plate in front of her, but it was empty. Resident #3 was observed reaching for Resident #4's food. The surveyor called the Administrator (who was doing medication pass on the other end of the and she rushed over. She took the hand of Resident #3 and escorted her away from the table and asked another staff member to take her away. The Administrator stated the resident was not hungry. She always ate everything in front of her. She had gained weight since she had been there. She stated Resident #3 was , as well as, the other residents at the table.

On at 8:45 a.m, Resident #3 was observed again at the dining table where Resident #4 and #5 were still sitting. Resident #3 was standing next to Resident #4 and had a fork in her hand and a whole piece of French toast on it. Resident #3 was attempting to eat it. Resident #5 stated it was Resident #4's French toast. The Administrator was called over by the surveyor again and the Administrator escorted her away from the table again. She stated that Resident #3 did that often. The surveyor asked who was supposed to be in the dining make sure this doesn't happen. She stated one of her assistants should be in the dining they were eating, but she was not there at this time. She was probably changing linens. The Administrator then went back to Resident #4 and cut her French toast up into smaller pieces for her. Resident #5 was interviewed at this time and she stated that Resident #3 would not take food off of her plate because she would hit her if she did.

On at 12:21 p.m. Resident #3 was standing behind Resident #4 who was in her wheelchair at the dining Resident #3 had a big wet spot pattern) on her pants between her legs and The Administrator escorted the resident down the hallway and asked a staff member to change her.

On at 3:16 p.m. Resident # 12 was sitting in her wheelchair in the dining Resident #3 was behind her pushing her in the wheelchair. Resident #12 was calling out for Resident #3 to stop pushing her. A staff member came over and escorted Resident #3 down the hallway.

Resident #3 was admitted on revealing she had mood as well as early She had dietary restrictions due to and sensitivities and was at high risk for escape. She was independent with all activities of daily living.

2. On at 1:15 p.m. Resident #7 was observed through an open door sitting in her reclined Gerichair. Her legs were kicking and her arms shaking and she was crying. She could not say what was wrong. Resident #7 was admitted to the facility on with diagnoses of , mood with features, and On at 2:40 p.m., the resident was again heard crying in her Her reclining chair was against the bed and the resident was sitting on the side of the bed and her legs hanging off the bed. She was really shaking her arms and she started talking about bad things happening, and

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that she left not to upset the baby. She asked for her window blinds to be opened and requested her sunglasses. She was crying the whole time. The surveyor asked if she wanted to lie down. She stated yes. The surveyor went to get a staff member to assist. Employee #4 returned to the [redacted] help the resident. Employee #4 leaned down to grab the resident to lift her and pull her up in bed. The resident hollared "let me do it", "I will do whatever you ask me to". The resident kept crying. Employee #4 wrapped her arms under the resident's armpits and started to drag her up in bed. The resident's legs remained on the floor and her upper torso leaned sideways. Employee #4 instructed the resident to lie back and push up with her feet on the bed. The resident did that and she scooted herself up in bed. The resident calmed down.

3. . Resident #9 was observed on [redacted] at 2:35 p.m. She was sitting in her wheelchair all the way down the end of the hallway (approximately 200 + feet) by herself. She had a bandage to her forehead above her left eye, [redacted] around her left eye, blue and black in color and a [redacted] under her eye dark blue in color. She also had a dressing on her right elbow and left upper arm. The resident stated she was not in pain but she did not know what happened. She stated she wanted to go home because she had 5 children to take care of. She was unable to tell the surveyor what year it was or the name of the facility she was in. She was only able to tell the surveyor her name.

A review of the clinical record revealed there was an incident report completed on [redacted] 2013 at 10:20 pm. It revealed around 10 p.m. Resident #9 was observed out of her [redacted] on her left eye. Checked for any injury and found nothing except the cut of her eye. The resolution was to clean the [redacted] on her left eye, apply bandage and put tape on it. The resident had a health assessment in her record (not dated). It revealed the the resident was alert and oriented x 2, with [redacted] Also under special precautions, it read [redacted] safety precautions".

The Administrator stated the resident was in her [redacted] must have hit her head on her nightstand. The Administrator on [redacted] at 3:37 pm stated she contacted the resident's son when this first happened and he did not want her sent to the hospital. The Administrator stated she did not call the physician. She stated that he was her new doctor, so she did not call him. She stated she was the one who did the dressing on her forehead and arms. (The Administrator was a nurse). She stated the resident was not on Limited Nursing Services. She stated she did the neurochecks and monitored the resident, but did not document of these actions. She did not call the doctor to see if he wanted her to be evaluated at the hospital or needed additional healthcare.

4. The Administrator on [redacted] at 4:30 p.m. was interviewed regarding the staffing for that day. She stated she had 4 caregivers, a cook, and herself on the schedule. Only three caregivers were seen. The Administrator stated the fourth staff member, Employee #6 was not there. He left around 8:30 that morning. She felt she did not need him, so she sent him to mow lawns. She stated he was only the housekeeper anyway.

Class II

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0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC

Based on observation , record review, and staff and resident interview, the facility failed to supervise and assist with Activities of Daily Living for residents, Resident #3 , #4, #5, and #7 (for dining, ambulation, transferring) and #12 (for care) placing them at risk for harm for a total of 5 of 12 sampled residents.

The findings include:

1. On at 8:15 a.m, three residents were sitting at the table in the corner of the Residents # 3, #4, and #5. Resident #5 was heard to yell "stop it". The surveyor went over to the table and Resident #5 stated that Resident #3 was messing with Resident# 4's food. Resident #3 had a plate in front of her but it was empty. Resident #3 was observed reaching for Resident #4's food. The surveyor called the Administrator (who was doing medication pass on the other end of the and she rushed over. She took the hand of Resident #3 and escorted her away from the table and asked another staff member to take her away. The Administrator stated the resident was not hungry. She always ate everything in front of her. She had gained weight since she has been here. She stated Resident #3 was as well as the other residents at the table.

On at 8:45 a.m, Resident #3 was observed again at the dining table where Resident #4 and #5 were still sitting. Resident #3 was standing next to Resident #4 and had a fork in her hand and a whole piece of French toast on it. Resident #3 was attempting to eat it. Resident #5 stated it was Resident #4's French toast. The Administrator was called over by the surveyor again and the Administrator escorted her away from the table again. She stated that Resident #3 did that often. The surveyor asked who was supposed to be in the dining make sure this doesn't happen. She stated one of her assistants should be supervising the dining meals, but she was not there. She was probably changing linen. The Administrator then went back to Resident #4 and cut her French toast up into smaller pieces for her. Resident #5 was interviewed at this time and she stated that Resident #3 would not take food off of her plate because she would hit her if she did.

2. On at 1:15 p.m. Resident #7 was observed through an open door sitting in her reclined Gerichair. Her legs were kicking and her arms shaking and she was crying. She could not say what was wrong. Resident #7 was admitted to the facility on with diagnoses of , mood with features, and On at 2:40 p.m., the resident was again heard crying in her Her reclining chair was against the bed and the resident was sitting on the bottom of the bed with her legs hanging off the bed. She was really shaking her arms and started talking about bad things happening and that she left not to upset the baby. She asked for her window blinds to be opened and requested her sunglasses. She was crying the whole time. The surveyor asked if she wanted to lie down. She stated yes. The surveyor went to get a staff member to assist. Employee #4 returned to the help the resident. Employee #4 leaned down to grab the resident to lift her and pull her up in bed. The resident hollered "let me do it", "I will do whatever you ask me to". The resident kept crying. Employee #4 wrapped her arms under the resident's armpits and started to pull her up in bed. The resident's legs remained on the floor and her upper torso leaned sideways. Employee #4 instructed the resident to lie back and push up with her feet on the bed. The resident did that and

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she scooted herself up in bed. The resident calmed down.

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On at 3:16 p.m. Resident # 12 was sitting in her wheelchair in the dining . Resident #3 was behind her pushing her in the wheelchair. Resident #12 was calling out for Resident #3 to stop pushing her. A staff member came over and escorted Resident #3 down the hallway.

Resident #3 was admitted on revealing she had mood as well as early . She had dietary restrictions due to and sensitivities and was at high risk for escape. She was independent with all activities of daily living.

4. The Administrator on at 4:30 p.m. was interviewed regarding the staffing for that day. She stated she had 4 caregivers, a cook, and herself on the schedule. Only three caregivers were seen. The Administrator stated the fourth staff member, Employee #6 was not there. He left around 8:30 this morning. She felt she did not need him so she sent him to mow lawns. She stated he was only the housekeeper anyway.

Class II

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and staff and resident interview, the facility failed to be free of physical for 2 of 11 sampled residents, Residents #2 and #7.

The findings include:

On at 8 a.m. Resident #2 was observed lying in her bed with a full side rail down the right side of her bed. The Administrator called down the hall and told the staff to remove the side rail from the resident's bed. The Administrator stated the resident was respite and was being discharged today.

On at 8:20 a.m., Resident #7 was sitting in a reclining chair with a tray attached to it across her lap. The resident was pleasantly and she stated she could not remove the tray and she could not get up. Employee #2 stated they place this on her chair at mealtimes and remove it afterwards. The family brought in the chair and the lap tray.

Later that day on at 11:50 a.m., Resident #7 was observed eating lunch without the lap tray on. Her chair was pushed up to the table.

Class II

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0051-Medication - Pill Organizers 58A-5.0185(2) FAC
Based on observation, record review, and staff and interview, the facility failed to properly manage a pill organizer for 1 of 11 sampled residents, Resident #1.

The findings include:

Resident #1 was admitted on [redacted] according to the Administrator. The resident had an old health assessment dated [redacted], 2013 revealing a history of [redacted] and short term memory problems. The section of the health assessment "Does the individual need help with taking his or her medications" was left blank. Under additional comments, it revealed medication reminder only.

On [redacted] at 12:30 p.m. , the Administrator was asked how the resident received his medications. She stated that he had a pill organizer and he gave himself the [redacted] injections. The pill organizer was observed on [redacted], at 12:30 p.m. For the 7 days, it had only the containers for Tuesday, Wednesday, Thursday and Friday (Morning, Noon, Evening, and Bedtime boxes). The Administrator stated the resident filled the pill organizer for himself for 5 days on Monday. She did not know where the Monday's container was. She stated that he went out with his family golfing sometimes so maybe they still had it.

The resident's [redacted] 2013 Medication Observation Record revealed he received medication in the morning as well as the evening and at bedtime. However, when the Friday's medication box was observed, it only had pills in it for the morning dose.

On [redacted] at 12:35 pm, Resident #1 was asked to fill his pill organizer for one day. He took a long time to read the label and would hold the medicine bottle in his hand. When he went through the pill bottles the first time, he started over again and began to place another set of medications in his pill organizer. He put an extra Donezepril 10 mg and an extra [redacted] in his pill organizer. He admitted he was not sure if he already put that pill in the container. He stated he had a really bad memory . The Administrator on [redacted] at 12:56 a.m. looked into the pill organizer and confirmed he did not fill it correctly. She stated that she did help him a little. She stated she did not document when she assisted him.

Class II

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observation, record review, and staff and resident interview, the facility failed to have licensed staff perform [redacted] glucose testing and administer [redacted] to two residents (Resident #1, #11), 2 of 12 sampled residents.

The findings include:

1. Resident #1 was admitted on [redacted] He did not have a new health assessment and only had one old health assessment on the resident's record dated [redacted] 2013. It revealed a diagnosis of [redacted] and short term memory loss. Under the section " Does the individual need help with taking his or her own medications" it was blank. Under additional comments/ observations it listed [redacted] Lantus 100units/ml inject 30

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units at bedtime and medication reminders only. On page 5 of this document dated it revealed assist with medications and self administer of and supervise of sugar checks. The Resident's Medication Observation Record (MOR) for 2013 revealed the resident was to have NPH 15 units two times a day at 7 am and 4 p.m.

The Resident was interviewed on 8:36 a.m.. He stated that he was on but was not sure of the specific type. He stated his sugar was 135 this a.m. The Administrator brought over the residents MOR and his medication bin. He was asked to pick out his and draw it up. The resident picked out R and stated he would draw up 8 units. The Administrator (who is nurse) was present and told the resident ," no, this is not the right She handed him the NPH and instructed him to draw up 15 units. The Resident stated the NPH was not right, that was too strong. The resident stated he did not think he had his today. He did not think that he gave the injections to himself.

With the assistance of the Administrator, the resident was able to draw up the 15 units of NPH and inject it in his abdomen on at 8:40 a.m. However, the resident did not use to clean the type of the vial nor did he use to clean his abdomen before the injection. The Administrator stated that she guessed she had to discharge the resident now. She stated that she was not always there to do assist the resident with his She stated unlicensed staff usually was here.

The family member of Resident #1 , the daughter in law was interviewed over the telephone on at 10:27 a.m. She stated the Resident lived with her and her husband for a long time. He could do his own sugar testing, but his memory was so bad, she would not trust him to give himself the She would not trust him with the dosages especially. The family member was not aware that the resident was not being supervised with his and that his health assessment stated he could do it himself.

2. Resident #11 had a health assessment dated that revealed a medical history of high , forgetful, and special precautions for elopement. Under the section "Does the individual need help with taking his or medications" it was left blank. Under section 3 "services provided to the resident" it listed supervision with medications. The resident's 2013 MOR revealed Easy Max test strips, sugars three times a day at 9 am, 1 pm, and 5pm. It also revealed Lantus inject 15 units at bedtime at 9 p.m

Resident #11 was interviewed on at 4:09 p.m. He stated that the girls (referring to unlicensed staff) do his sugar testing at night and then they give him the He stated he did not remember giving himself any injections. The Administrator was present and kept telling the resident, "we do not give you the injection, you do it for yourself". The resident kept responding that the girls did it.

On at 4:10 p.m. , Resident #11 was asked to demonstrate how he tested his own sugar levels. He stated the girls did it. He attempted to do it four times unsuccessfully. He kept asking questions what to do. The Administrator had placed the lancet in his hand and told him to stick his finger. The first two times it did not break the skin. The last time, the Administrator took off the cap on the lancet and told the resident to stick himself with the needle sticking out. The resident stuck his finger and was able to get drawn. The resident tried to put the on the test strip but only a little got on it. The sugar machine gave an error reading. The Administrator gave up at this point of trying to let him do it himself and she did the sugar testing for him.

Employee #4 on at 4:22 p.m. was interviewed. She stated that sometimes Resident #11 was not able to do his own sugar testing so employee #2 did it for him. Employee #2 was an unlicensed staff member.

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Class II

0054-Medication - Records 58A-5.0185(5) FAC
Based on record review and staff interview, the facility failed to maintain accurate Medication Observation Records (MORS) for Residents #1, #3, #7, #8, and #11, 5 of 12 sampled residents.

The findings include:

1. On [redacted] at 9:39 a.m. the Administrator was observed flipping through the MORs and occassionally signing off medications. She was asked what she was doing. She stated she was signing some of the blanks. She stated that she gave the medications, she just did not sign them at the time she gave it.

2. Resident #1 had a [redacted] 2013 MOR for NPH [redacted] to be given at 7 am and 4 pm. It was blank on the 20th and 21st. The resident also had a sliding scale [redacted] for [redacted] sugars over 150.
The facility recorded the resident's [redacted] sugars daily from [redacted] 22- [redacted] 2013.

On [redacted] before breakfast, the [redacted] sugar was 158. On [redacted] before breakfast the [redacted] sugar was 163 and before noon 183. Staff wrote 2 units each time next to the [redacted] sugar on the log but the Medication Observation Record was blank on those days for the sliding scale.

Also on [redacted] before supper, the [redacted] sugar level was 138 and 2 units was given, when none should have been given. The [redacted] sugar log did not reveal which staff member was involved with recording the [redacted] sugar level or how much [redacted] was given.

The MOR did not reflect that the resident received any sliding scale [redacted] The Administrator on [redacted] at 12:54 pm confirmed that there were two days when NPH [redacted] (20th and 21st) were blank and she just filled them in today because the resident self-administered.

3. Resident # 3 had a [redacted] 2013 MOR for [redacted] 5 mg to be taken once daily. It was circled on the 22nd, 23rd, and 24th and it was blank on the 25th. There was also [redacted] order 15 mg one tablet at bedtime. It was circled on the 24th at 9 pm. The Administrator on [redacted] at 11:52 a.m. stated she ran out of these medications. She stated she usually documented on the back of the MOR the reason why she did not give it. She confirmed she did not document why she did not give it. The back of the MOR was blank.

4. Resident #7 had a [redacted] 2013 MOR for [redacted] 0.5 mg, take one tablet by mouth twice a day. For this medication, a hand written note read "alternate with [redacted] only if needed." There were many times when the staff circled their initials and did not give this medication. However, there was no explanation why this was not given. The label of this medication also had the note handwritten "alternate with [redacted] if needed for agitation."

There was also a medication card for [redacted] 0.5 mg, take 1/2 tablet by mouth in the morning and at bedtime. A handwritten note "alternate with [redacted] if needed for agitation" was seen on the label. However, the [redacted] was not listed on the MOR.

Also there was no physician's order for the [redacted] and [redacted] to be alternated. On [redacted] at 11:40 a.m., the Administrator stated she was alternating the medication for about two weeks now. She also confirmed

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unlicensed staff was assisting with the as needed medication for this resident.

5. Resident #8 was admitted on . She had a health assessment dated and her medication list on this was for 10 mg daily, 20 mg twice a day, 10 mg daily, 500 mg at hour of sleep, 81 mg daily, 10 mg at bedtime, 100mg daily, FeS04 325 mg daily, 5 mg daily, and 1000 mg 2 x's day.

The Administrator was interviewed on at 3:25 p.m. She stated the resident only got there two days ago. She did not have any medications yet for Resident #8. The nephew was supposed to bring them. She did not have a Medication Observation Record filled out yet either. She stated she had been giving some of the medications to the resident. A few of them were sent over from the other facility. She was asked to see the medications that she gave. She could not find them at the time of the survey.

6. Resident #11 had a 2013 MOR for Lantus injection 15 units at bedtime. It was not signed off for the whole month. There was also 100 units/ vial inject three times a day depending on sliding scale. The sliding scale was not on the MOR. The resident's sugar was recorded for the month of 2013. There were many entries when Employee #4 (non licensed staff) signed next to the sugar level and a number of units. The Administrator on at 4:15 pm stated the MOR was blank because the resident did the himself.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observation, record review, and staff interview, the facility failed to store refrigerated in a locked compartment for Residents #1 and #11 and failed to discard discontinued for Resident #1, 2 of 12 sampled residents.

The findings include:

1. On at 8:36 a.m, the medication bin for for Resident #1 was observed in the refrigerator in the staff break . The plastic medication bin was not locked, nor was the staff break , nor was the refrigerator door. In the bin was R NPH and . The had an expired date of . Review of the resident's Medication Record revealed only R and NPH was ordered. The was not. The Administrator on at 9:21 a.m. confirmed the medication bins were not under a locked compartment and she did not know why there was in his box. She did not know when the resident's was discontinued.

The Resident's power of attorney/ health care surrogate who was the daughter-in-law was interviewed on at 10:27 a.m over the telephone. She stated that the Veterans Administration (VA) did change his at the beginning of the year. She stated the VA changed the kind of because only certain types were covered.

2. Resident #11 also received and had a plastic bin for his medication that was to be kept in the same refrigerator as Resident #1. At first the bin could not be found and then the Administrator found the resident's

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bin on at 4:09 p.m. It was found on top of the refrigerator. The resident had Lantus in the bin. There was also a vial of R with a label that was difficult to read. The Administrator stated the R did not belong to Resident #11, but belonged to Resident #1. She did not know how it had gotten in there.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, record review, and staff and resident interview, the facility failed to have properly labeled medications by pre-filling syringes for residents for later use for Residents #1 and #11, 2 of 12 sampled residents.

The findings include:

The findings include: On at 9:21 a.m. the medication bin was observed for Resident #1. It had a vial of R and in the bin. There were also two syringes in the bin. One was not used, the other one had clear fluid in it and it was at the 15 line. The Administrator stated that this was his NPH that the Resident filled himself. They kept it in the refrigerator and when it was time to inject it, the staff handed it to him. The syringe did not have a label on it to identify what type of it was or who it belonged to. The Administrator confirmed this on at 9:22 a.m.

Resident #9 on at 4:09 p.m. stated the girls did his sugar testing and then gave him the (The girls he was referring to were the unlicensed staff members). The resident's could not be located at first. After looking for it for about 5 minutes, the Administrator found it. She stated his medication bin was on top of the refrigerator. She was not sure how it had gotten there. The resident had Lantus insuin and R in his bin. She confirmed that she did have prefilled syringes for this resident also and had it in there for him to use. She did not list the type of or name of the resident on it either. She stated it was prefilled for Tuesday and Wednesday.

Class II

0057-Medication - Over The Counter (OTC) Products 58A-5.0185(8) FAC
Based on observation, record review, and staff interview, the facility failed to properly label over the counter (OTC) medications for 1 of 12 sampled residents, Resident #7.

The findings include:

On at 11:40 a.m., the medication labels for Resident #7 was were reconciled with the Medication Observation Record. A review of the 2013 Medication Observation Record revealed C 500 mg daily was listed.

The Administrator was asked for the bottle of C for this resident. The Administrator produced a bottle of C 500 mg. It was an over the counter medication. It did not have the resident's name on it. The Administrator confirmed that the resident's name had not been placed on the OTC medication.

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0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on observation, record review, and staff and resident interview, the administrator failed to operate the facility in an effective manner to ensure that staff had appropriate background screening and that residents received adequate care in the areas of supervision, medication managment, and resident rights, potentially affecting all (22) residents in the building.

The fiindings include:

The Administrator failed to have background screening for 3 of 6 employees. (See Z815).

The Administrator failed to assess residents to ensure appropriateness of admission, and the facility's ability to provide needed care and services and to ensure health assessments were correct (See A0008).

The Adminstrator failed to prevent physical and did not notify a physician of a with injury. (See A-0030 resident rights).

The Administrator allowed an admission for a resident and did not have the supplies and medication to provide him/her (See A-0007).

The Administrator failed to provide proper staff to supervise an resident who disrupted meal times and needed assistance with activites of daily living (See A-0025).

The Administrator failed to ensure that a resident using a pill organizer was capable of doing so (See A-0051).

The Administrator failed to have licensed staff assist with sugar monitoring and injections for residents who were uncapable of doing so (see A-0053).

The Administrator failed to store and label medications properly (See A-0055, A-0056 and (A-0057) and failed to maintain proper Medication Observation Records (See A-0054).

The Administrator failed to maintain an up to date admission/discharge log (See A-0160).

The Administrator failed to obtain resident contracts upon admission to the facility (See A0167).

Class II

0079-Staffing Standards - Levels 58A-5.019(4) FAC
Based on observation, record review, and staff interview, the facility failed to have enough staff to provide the care and services and supervision needed for Residents #2, #3, #4, #5, #7 , #8, #9 and #12, 8 of 12 sampled residents.

The findings include:

1. On at 8 a.m. during the initial tour of the building, dirty linen piles were observed in the hallway, one each outside of 4 different The Administrator was accompanying the surveyor and she went to one of the other staff members and told her to pick up the linen. The Administrator stated she knew better than to pile them

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on the floor in the hallway. On at 8:04 a.m. Resident #2 was observed in her bed with a full side rail on the right side of her bed. Also Resident #8 was heard on at 8:05 a.m. calling for help. When the surveyor went into the , she asked to be turned in bed and her wheelchair to be turned around so she could reach it. Resident #9 was in her at 8:06 a.m. She had a bandage above her left eye and a left eye. She did not know how it happened. The Administrator stated she had a and hit her head.

2. On at 8:15 a.m, three residents were sitting at the table in the corner of the . Residents # 3, #4, and #5. Resident #5 was heard to yell "stop it". The surveyor went over to the table and Resident #5 stated that Resident #3 was messing with Resident# 4's food. Resident #3 had a plate in front of her but it was empty. Resident #3 was observed reaching for Resident #4's food. The surveyor called the Administrator (who was doing medication pass on the other end of the and she rushed over. She took the hand of Resident #3 and escorted her away from the table and asked another staff member to take her away. The Administrator stated the resident was not hungry. She always eats everything in front of her. She has gained weight since she has been here. She stated Resident #3 was , as well as, the other residents at the table.

On at 8:45 a.m, Resident #3 was observed again at the dining table where Resident #4 and #5 were still sitting. Resident #3 was standing next to Resident #4 and had a fork in her hand and a whole piece of French toast on it. Resident #3 was attempting to eat it. Resident #5 stated it was Resident #4's French toast. The Administrator was called over by the surveyor again and the Administrator escorted her away from the table again. She stated that Resident #3 does that often. The surveyor asked who was supposed to be in the dining make sure this doesn't happen. She stated one of her assistants but she was not there. She was probably changing linen. The Administrator then went back to Resident #4 and cut her French toast up into smaller pieces for her. Resident #5 was interviewed at this time and she stated that Resident #3 would not take food off of her plate because she would hit her if she did.

On at 12:21 p.m. Resident #3 was standing behind Resident #4 who was in her wheelchair at the dining . Resident #3 had a big wet spot on her pants between her legs and . The Administrator escorted the resident down the hallway and asked a staff member to change her.

On at 3:16 p.m. Resident # 12 was sitting in her wheelchair in the dining . Resident #3 was behind her pushing her in the wheelchair. Resident #12 was calling out for Resident #3 to stop pushing her. A staff member came over and escorted Resident #3 down the hallway.

Resident #3 was admitted on revealing she had mood as well as early . She had dietary restrictions due to and sensitivities and was at high risk for escape. She was independent with all activities of daily living.

3. Resident #7 was observed on at 2:40 p.m. Her door was opened in her she was crying. She was sitting on her bed with her arms shaking . Her reclining chair was next to the bed. The resident was talking about feeling stupid and needing her sunglasses and asked for someone to open her window blinds. The Surveyor tried to console the resident. She was asked if she would like to lie down. She replied yes. The surveyor went to get a staff member to help Resident #7. When the staff member arrived, Employee #4, the Resident began to cry more. The resident told the employee, "let me do it. I will do whatever you ask me to do". Employee #4 wrapped her arms around the resident slightly below her arm pits and began to pick the resident up and slide her up the bed. The resident's feet remained on the floor and her upper body was leaning sideways. The resident was trying to assist and kept saying let me do it. Employee #4 finally instructed the resident to lie

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down and push up with her feet. Employee #4 got the resident to lie down in bed.

4. The Administrator on [redacted] at 4:30 p.m. was interviewed regarding the staffing for that day. She stated she had 4 caregivers, a cook, and herself on the schedule. Only three staff members was observed in the building. One of the staff members, Employee #6 was not there. The Administrator stated he left around 8:30 this morning. She felt she did not need him so she sent him to mow lawns. She stated he was only the housekeeper anyway.

Class III

0160-Records - Facility 58A-5.024(1) FAC
Based on record review and staff interview, the facility failed to have an up to date admission/discharge record for 3 newly admitted residents, Residents #1, #2, and #10.

The findings include:

Resident #2, a respite resident was observed on [redacted] at 8 a.m. lying in her bed with a full side rail on the right side of her bed. The Administrator stated she was admitted on [redacted] and was leaving today.

The Administrator on [redacted] at 8:25 a.m. was asked who would be a good person to interview? She replied Resident #1 who was newly admitted. The Administrator brought over the Admission/Discharge log and was asked to show the surveyor where these two residents were on the log (Residents #2 and #1) . She stated they were not on there. She added them in at that time.

The Administrator was also asked if there were any additional residents newly admitted not on the log. She looked over the log and stated Resident #10 who was admitted on the 15th. She then added this resident to the Admission/Discharge log.

On [redacted] at 12:30 pm , the Administrator again confirmed all three residents were not on the Admission/ Discharge log and she wrote them in that day in the surveyor's presence.

Class III

0167-Resident Contracts 58A-5.025(1) FAC
Based on record review and staff interview, the facility failed to have contracts for 2 of 3 newly admitted admitted residents, Residents #1 and #8.

The findings include:

Resident #1 was on [redacted] He had a San-Juan-Wiley Retirement Home Contract in his record partially completed in the amount of $1400 per month. However , it was not signed by the resident/ guardian or the Administrator or facility designee.

The Administrator on [redacted] at 8:25 a.m stated the resident's daughter-in-law was the power of attorney and she had not been in yet to sign the contract.

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Resident #8 was admitted to the facility on . She had a San Juan-Wiley Retirement Home contract in her record partially completed in the amount of $2500 per month. However it was not signed by either the resident / guardian, or the Administrator or facility designee.

The Administrator on at 3:25pm stated that the nephew of Resident #8 was supposed to come in and fill out the paperwork.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on employee record review and staff interview, the facility failed to have an Level II Background screening for 3 of 6 sampled employees, Employees #2, #5, #6.

The findings include:

Employee #2 , a caregiver was hired , 2013. She did not have documentation of an eligible background screening.

Employee #5, a caregiver was hired in 2012. She did not have documentation of an eligible background screening.

Employee #6, a housekeeper was hired . He did not have documentation of an eligible background screening.

The Administrator was interviewed on at 1:14 pm. She stated she had been having problems with some of the screenings and she needed help.

Unclassified