STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967589	07/09/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Rosie's Place	1102 Sw Ivanhoe Street Port Saint Lucie, FL 34983	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - [redacted] S-S= D
St - A - 0085 - 58a-5.0191(6) Fac - Training - Nutrition & Food Service S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= D

Specific Tag Findings:

0000-Initial Comments

An Assisted Living Facility biennial relicensure survey was conducted in conjunction with the Limited Mental Health (LMH) survey on [redacted]. Rosie's Place, had licensure deficiencies found at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation and interview, it was determined the facility failed to ensure access to adequate and appropriate health care consistent with established and recognized standards within the community was provided for each resident, specifically related to staff's failure to wash/sanitize hands during assistance with medications, for 3 out of 3 sampled residents observed (Residents #1, #2, and #3).

The findings include:

During observation of assistance with medications with Employee A, conducted on [redacted] beginning at approximately 8:55 AM, she provided assistance with medications for 3 residents (Residents #1, #2, and #3). She was not observed to wash or sanitize hands before, during, or after providing assistance with medication for these residents.

During interview with the Administrator and Employee A, conducted on [redacted] beginning at approximately 10:00 AM, they were informed of this observation. Employee A acknowledged she did not wash or sanitize hands prior to or between providing assistance with medication for these residents.

Class III

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

Based on observations, interviews, and record reviews, it was determined a direct care staff member prepared a syringe for injection for 1 of 3 residents observed during assistance with medications (Resident #3); and a direct care staff member failed to read the medication label and prepare oral medication for the resident at the time of providing assistance and did not observe the resident take the medications, for 1 out of 3 sampled residents observed during assistance with medications (Resident #1).

The findings include:

1) During observation of Employee A (direct care staff), conducted on at approximately 9:05 AM, she was observed handing Resident #3 an pen and the resident was then observed to self-inject the medication (resident was not observed to dial the dosage on the pen). Employee A was asked if she dialed the dose of on the pen. She replied that she had dialed 20 units per Resident #3's instruction. She was informed that she could not dial the for any resident. Resident #3 was asked if this is something the staff routinely does for her. This resident turned her head and refused to talk to this surveyor. (A couple of attempts to interview this resident were made throughout the day and she continued to refuse to speak to this surveyor).

During subsequent interview with the Administrator and Employee A, conducted on at approximately 10:00 AM, the Administrator was informed of this observation. The Administrator stated that this resident usually handles the pen herself. Employee A state sometimes this resident forgets her glasses or she has trouble with her hands so the resident asks her to dial the pen and she does this for the resident.

2) During observation of Employee A, conducted on at approximately 8:55 AM, she was observed to obtain a small white plastic cup from the cabinet that contained 5.5 pills that were previously prepared (1 large white oval pill; 1 medium white oval pill; 1 beige large oval pill; 1 round white pill; 1 small orange pill; 1/2 small white oval pill - picture taken). Employee A provided this cup of medications to Resident #1 at the dining and then Employee A walked into the kitchen. This resident proceeded to take this medication with her juice. Upon return of Employee A, she was asked what the medications were and why she was providing previously prepared medications to this resident. She stated that she did not know what medications these were but that she could find out. She stated she was giving this resident these medications like this because there had been some medication changes and her medications were sent back to the pharmacy and new ones were to arrive today. She stated a dose of Resident #1's medications were kept out for this morning.

During subsequent interview with the Administrator and Employee A, conducted on at approximately 10:00 AM, the Administrator was informed of this observation. She acknowledged this technique did not follow regulatory requirements and that the medications should have been obtained in front of this resident; the medication identified; and the staff member should have observed her

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take the medications.

During record review and interview with the Administrator, conducted on [redacted] at approximately 1:50 PM, Resident #1's record did not reflect any medication changes since [redacted] related to a change of [redacted] to discontinue 12.5mg [redacted] (twice a day) dosage and start [redacted] 25mg [redacted] (twice a day). The Administrator acknowledged the [redacted] 2013 MORs noted that from [redacted] that the 12.5mg and 25mg dose of this medication was signed as being provided. Employee A stated only [redacted] 25mg was provided by her. But she acknowledged signing the 12.5 mg dose of this medication on the MOR. She could not provide an explanation as to why, just that she must have made a mistake in signing the MOR.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC

Based on observation, interview, and record review, it was determined the facility failed to ensure any change in directions for the use of a medication was accompanied by a written medication order issued and signed by the resident's health care provider; that the directions were promptly recorded on the MOR (Medication Observation Record); and an "alert" label was placed on the container of the medication, for 1 out of 3 sampled residents reviewed during observation of assistance with medications (Resident #1).

The findings include:

During observation of Resident #1's medications with the Administrator and Employee A, conducted on [redacted] at approximately 10:20 AM, this resident's bottle of [redacted] (filled on [redacted] 10gm/15ml 20cc daily at 8:00 AM contained the letter PRN handwritten. This bottle did not appear to be missing any of the liquid contents. Employee A and the Administrator stated this medication was changed to a PRN (as needed) medication. Review of Resident #1's record did not include an order substantiating this statement. The Administrator called the pharmacy and asked for a clarification for this medication. This clarification was not obtained during this inspection. The Administrator acknowledged the [redacted] 2013 MOR (Medication Observation Record) did not indicate this medication was provided to Resident #1.

Class III

0082-Training - [redacted] 58A-5.0191(3) FAC

Based on record review and interview, it was determined the facility failed to ensure all employees that provide direct care to residents completed a one-time education course on [redacted] and [redacted] within

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30 days of employment, for 1 of 4 sampled employees (Employee A).

The findings include:

During employee record review and interview with the Administrator, conducted on at approximately 11:07 AM, she was unable to locate any documentation related to and training for Employee A (date of hire noted as , who regularly works the 6:00 AM - 6:00 PM shift and provides direct care to residents.

Class III

0085-Training - Nutrition & Food Service 58A-5.0191(6) FAC

Based on record review and interview it was determined this facility failed to ensure the Administrator who is responsible for the facility's food service and the day-to-day supervision of food service staff obtained, annually, a minimum of 2 hours of continuing education in topics pertinent to nutrition and food service in an assisted living facility (Employee D).

The findings include:

During entrance conference with the Administrator, conducted on at approximately 9:30 AM, she was asked who was the Food Service Designee for this facility. She replied that she was.

During employee record review and interview with the Administrator, conducted on at approximately 12:30 PM, she was asked to locate documentation that she (Employee D) had received the required 2 hours of continuing education in topics pertinent to nutrition and food service in an assisted living facility. She could not locate this documentation.

Class III

0161-Records - Staff 58A-5.024(2) FAC

Based on record review and interview, it was determined the facility failed to ensure each staff member had documentation of verification of freedom from communicable including for 3 out of 6 employee records reviewed (Employee B, Employee C and Contractor E).

The findings include:

During employee record review and interview with the Administrator, conducted on beginning at approximately 11:07 AM, she was asked to locate current documentation of freedom

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from communicable ..... including ..... for the following employees and was unable to locate this documentation:

a) Employee B (date of hire noted as ..... The Administrator stated the only documentation on file is a negative ... test dated ..... She acknowledged there was no statement indicating this employee was free from communicable ..... including .....

b) Employee C (date of hire noted as ..... 1997): The Administrator stated where she goes they no longer provide that statement without an ... test. She acknowledged there was no statement indicating this employee was free from communicable ..... including .....

c) Contractor E (date contracted noted as ..... The Administrator stated she was not aware she needed a statement indicating this individual was free from communicable ..... including ..... until she was actually providing services to residents. She stated this employee/individual has only been providing staff trainings in this facility in which 5 residents currently reside.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on record review and interview, it was determined this facility failed to conduct the required background screening for an individual contracting with the facility whose responsibilities require her to provide personal care or personal services directly to clients, for 1 out of 1 contracted employee (Contractor E).

The findings include:

During employee record review and interview with the Administrator, conducted on ..... at approximately 12:30 PM, the Administrator indicated that Contractor E is the RN (Registered Nurse) for the facility's ECC (Extended Congregate Care) residents. The Administrator stated the facility does not currently have any ECC residents, but that this RN has provided staff trainings in this facility. The Administrator acknowledged that by providing trainings to the staff of this facility (on site) that this RN had access to current residents and their living areas. The Administrator stated, she had not had a background screening conducted for Contractor E because she did not think she had to get one for her until she was working with ECC residents.

Unclassified

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Rosie's Place
1102 SW Ivanhoe Street
Port Saint Lucie, FL 34983

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2013 by a representative from 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 (30)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,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure: State 5000-3547 Form
XG90

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