STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910320	08/29/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Golden Retreat Shelter Care Ce	4410 Moncrief Rd. W. 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 - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
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 - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments

An unannounced biennial licensure survey with Limited Mental Health was conducted at Golden Retreat in Jacksonville, Florida on 2013. Licensure deficiencies were identified as a result of the survey.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on resident record review and staff interview, the facility failed to ensure that resident health assessments contained complete information regarding whether the individual will require any assistance with the administration of medication for 3 of 3 sampled residents records. (#1, #2 and #3).

The findings include:

1.) A review of Resident #1's record and health assessment, revealed that Section 2-B of the form regarding self-care and general oversight was not completed. Subsection (B.) regarding assistance with medication was not checked to indicate whether the resident required assistance. The form was not marked to indicate if the resident required assistance with "self-administration" or "medication administration".

2.) A review of Resident #2's record and health assessment, revealed that Section 1-C of the form regarding the resident's status was not completed. The form was not marked to indicate whether the resident; had 3, or 4 pressure sores, posed a danger to self and others or required 24 hour nursing or care.

3.) A review of Resident #3's record and health assessment, revealed that Section 1-D of the form regarding whether the resident's "needs could be met in an assisted living facility which is not a medical, nursing or facility" status was not completed. The form was not marked to indicate whether the resident's needs could be met.

Section 2-B of the form regarding self-care and general oversight was not completed. Subsection (B.) regarding assistance with medication was not checked to indicate whether the resident required assistance. The form was not marked to indicate if the resident required assistance with "self-administration" or "medication administration".

An interview with administrator was conducted on at 10:55 AM. The administrator confirmed that the

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information was missing from the health assessments.

Class III

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

Based on interviews with residents and staff, and resident record review, the facility failed to ensure 1 of 22 sampled residents (Resident #7) was treated with respect and consideration in full recognition of his individuality and was allowed to make independent personal decisions.

The findings include:

An interview was conducted with Employee G at 11:00 am on . She stated that assistance with medication administration occurred daily, and that at 9:00 am, any residents who refused their medication were denied their snack. She explained, "if we tell (the residents) 'no snacks', then they will usually take their medication". She stated there had been residents who got so upset by this, and demanded their snack, that they had to be . One of the residents she recalled to refuse his medication often was Resident #7.

An interview was conducted with Resident #7 in his 12:11 pm on . When asked what happened if he refused to take his medications, he replied, "then I don' t get my snack. They don ' t let me". When asked if this happened often, he said "yes, it happened a lot". He said it made him feel "bad" when he did not get his snack. He was unable to provide any name of those who refused him snacks.

A record review for Resident #7 found he was admitted and was The resident health assessment (AHCA form 1823) dated reflected diagnoses including "rule out early Resident #7 was noted to require assistance with the self-administration of medications, and took (an anti-ps 5 milligrams (mg) daily, trilafon (an anti-ps 8 mg twice daily, and aricept (a medication used to treat 10 mg every night at bedtime. Resident #7 also received Limited Health Services from the facility. The following documents, which were located in Resident #7's record, were reviewed in their entirety: (1). the facility's admission and retention policies; (2). facility rules and regulations; (3). the resident bill of rights; (4). a resident contract dated and (5). a resident service plan for assitive care services dated None of the documents indicated that Resident #7 would be denied his snack should he refuse to take his medications. In addition, an Annual Community Living Support Plan dated was reviewed, and indicated Resident #7 would receive medication management services. There was no mention of consequences of refusal of medications.

An interview was conducted with the Administrator at 1:55 pm on . She denied any knowledge of the practice of witholding snacks when medications were refused. She stated all residents, to her knowledge, were offered snacks in the evening.

Class III

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

Based on observation, record review, and staff interview, the facility failed to provide assistance with self administration of medications according to required procedures for 5 of 11 residents reviewed (Residents #17,

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#18, #19, #20, #21).

The findings Include:

1. The Medication Aide (employee H) was observed on at 10:10 AM signing the Medication Observation Record (MOR) for providing of morning medications for residents #17, #18, #19, #20, and #21. The Residents were not in the facility at that time.

2. During an interview with the Medication Aide on at 10:15 AM she stated she had pre poured medications for residents #17, #18, #19, #20, and #21 on and placed the medication cup in a locked closet in the hallway near the dietary department. The Medication Aide demonstrated to the surveyor the location of the closet and how the pre poured cup with medications were sealed in a plastic bag. "In the morning, another medication aide provides them to the resident at 6:30 AM because I don't come in until 8:00 AM." She said she signed MOR during her morning medication pass later in the day.

3. During an interview with the Assistant Administrator on at 3:00 PM she stated the facility has been using the system of "pre-pouring the medications and placing them in the hallway closet for use on the next day" for several years.

Class III

0054-Medication - Records 58A-5.0185(5) FAC

Based on observation, record review, and staff interview, the facility failed to maintain an accurate Medication Observation Record (MOR) for 6 of 11 records reviewed. (Residents #17, #18, #19, #20, #21, and #22). The MOR must be immediately updated each time a medication is offered or administered.

The findings include:

1. Observation on at 10:45 AM of the Medication Aide (employee H) signing the MOR for resident #22 indicating that 150 mg was administered. A review of the medication cart revealed the medication was not in stock in the cart and therefore, could not have been administered.

2. During an interview with the Medication Aide on at 10:48 AM she stated "we must be out of that medication. I will reorder it." When asked by the surveyor how long it had been out of stock, the Medication Aide stated she did not know how long it had been out of stock.

3. During a phone interview with the pharmacy tech for Guardian Pharmacy on at 1:15 PM he stated "the pharmacy has not sent since last month. It was discontinued on 12."

4. A review of the MOR showed the medication had been signed off as provided to Resident #22 every day from 12 through the date of (49 days).

5. The Medication Aide (employee H) was observed on at 10:10 AM signing the MOR for providing of morning medications for residents #17, #18, #19, #20, and #21. The Residents were not in the facility at that time.

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6. During an interview with the Medication Aide on ..... at 10:15 AM she stated she had pre poured medications for residents #17, #18, #19, #20, and #21 on ..... and placed the medication cup in a locked closet in the hallway near the dietary department. "In the morning another medication aide gives them to the residents at 6:30 AM because I don't come in until 8:00 AM." She said she signed MOR during her morning medication pass later in the day.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on a review of employee records and staff interview, the facility failed to ensure annual documentation of freedom from ..... for 1 of 22 sampled employees (Employee C).

The finidngs include:

An employee record review conducted for Employee C found she was hired ..... as a Staff Aide. Her most recent ..... screening was performed on ..... and expired .....

An Interview was conducted with the facility Secretary at 1:25 pm on ..... She stated all employees were scheduled to be screened for ..... this coming ..... She acknowledged Employee C's screening had expired, and stated she would have to schedule her for a new screening.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC

Based on a review of employee records and interview with staff, the facility failed to provide the required in-service trainings to 2 of 22 sampled employees (Employees B and C) who provided care to the residents.

The findings include:

A review of Employee B's personnel file found she was hired on ..... as a Staff Aide. The file contained no documentation that she received the required 1 hour in-service training in ..... control, including universal precautions, and facility sanitation procedures before providing personal care to residents. In addition, there was no evidence Employee B received the required 1 hour in-service training in facility emergency procedures, including chain-of-command and staff roles relating to emergency evacuation, within 30 days of hire, or anytime thereafter.

A review of Employee C's personnel file found she was hired on ..... as a Staff Aide. There was no documentation this employee received the 1 hour in-service training in facility emergency procedures within 30 days of hire, or anytime thereafter.

An interview was conducted with the Administrator at 2:05 pm on ..... She confirmed she had not provided emergency preparedness training for employees B and C, and acknowledged the missing training in .....

control for Employee B.
Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observation of the facility and interview with the Administrator, the facility failed to maintain flooring, fixtures, and in good working order in 9 of 36 resident and 4 of 8 resident observed during the facility tour.

The findings include:

Tour of the facility started at 9:40 am and found the following physical plant concerns:

a. In the corners and along the walls of , the vinyl commercial baseboard and adjacent floor tiles were observed to be chipped, buckled, and stained.

b. 's baseboards and adjacent floor tiles were stained and in need of repair, and the bottom of one closet doors was broken and

c. The bottom corner of the wall mounted switch plate in had broken off.

d. The entire left side of the door jamb inside of had broken and crumbling plaster from floor to ceiling. This had a nightstand with a broken drawer.

e. In , there was a broken chest of drawers.

f. The bathtub in the 13 and 15 needed re-finishing.

g. In , the floor tiles along the baseboards were stained and discolored.

h. In , 2 linear feet of baseboard was missing completely. In addition, a broken lamp was observed on the nightstand, and a 4-drawer was broken beyond use. One drawer sat on top of the dresser and the remainder were missing.

i. In , broken and peeling baseboards and mismatched floor tiles were observed.

j. In , there was a broken floor tile inside the entrance door. A atched and stained tile repair job was evident.

k. In #1 and # 2, a significant amount of mildew and lime scale had built up on the floor tiles in corners, around the tubs, and behind the toilets, and the faucet in had duct tape around the handles and spiggot.

l. The to had broken ceramic toilet paper holder with exposed rough edges.

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m. There was a cockroach inside the doorway of

n. The men's to had leaves on the floor, and what appeared to be coffee grounds in the sink. The tub needed re-finishing as it had missing and flaking surfaces around the drain.

o. Observation of the dining found stained, rusted, chipped and atched floor tiles, and baseboards that were pulling away from the walls. Some of the tile had been replaced and was a bright white that stood out next to the older.

An interview was conducted with the Administrator at 2:40 pm. She acknowledged the facility needed repairs, and stated they were "working on it."

Class III

L243-LMH - Training 58A-5.0191(8) FAC

Based on a review of employee records and interview with staff, the facility failed to ensure that 1 of 22 sampled employees (Employee B) received the required 6 hours of specialized training in working with individuals with mental health diagnoses.

The findings include:

A review of Employee B's personnel file found she was hired on as a Staff Aide. On she received a 1-hour training in Limited Mental Health ADLs (activities of daily living) and job responsibilities. There was no documentation reflecting the completion of the additional 5 hours of training required on this topic.

An interview was conducted with the Administrator at 2:05 pm on She confirmed the missing training for Employee B.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Golden Retreat Shelter Care Center
4410 Moncrief Road West
Jacksonville, FL 32209

Dear Administrator:

This letter reports the findings of a state biennial licensure with Limited Mental Health survey that was conducted on 2013 by representatives 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 surveyors. Should you have any questions please call this office at

Sincerely,

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

KW/sm
Enclosure

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