STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910541	08/29/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Summer's Landing	**615 Florida Avenue Lynn Haven, FL 32444**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

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0000-Initial Comments

On 28-29, 2013, an unannounced biennial state licensure survey was conducted at Summer's Landing Assisted Living Facility. There were deficiencies found at the time of the survey.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on observation of residents, staff interview, and record review the facility failed to have completed Resident Health Assessments for Assisted Living Facilities (1823) according to the needs of the resident for 2 of 2 residents (#5 and #8).

The findings are:

A review of Resident #8's record revealed an 1823 dated . The 1823 on page 1 under the section for Medical history and diagnoses: says "See note". A review of the 1823 and the record failed to reveal any note with medical history or diagnoses. Further review of the 1823 revealed Section C with the question Does the individual need help taking his or her medications? Yes___ No__. If yes, please place a checkmark in front of the appropriate box below: _____ needs assistance with self-administration of med's ___ needs total assistance with Administration of Med's. The box is labeled yes for needing help but there is no indication of what type of assistance is needed.

An interview was conducted with the Resident Care Coordinator (Employee E)on about 6:38 am . She stated, " I do not see the note that is supposed to be attached " . She confirmed there is no diagnosis on the 1823 for Resident # 8.

A review of Resident # 5's file revealed an 1823 dated . The 1823 in Section I for Activities of Daily Living for section to be marked for: I Independent, S needs supervision, A needs assistance there is nothing marked. The comment section indicates the resident does not ambulate. In addition Section 2 B for Self Care and General Oversight Assessment. B. Does the individual need help with taking his or her medications? Yes___ No___. If yes please place a checkmark in front of the appropriate box below: ____ Needs Assistance with self Administration of Medications _____ Needs Medication Administration. The boxes are marked yes and that the resident needs medication administration.

An observation was made of the resident ambulating to the dining for the noon meal using a rolling walker.

An interview was conducted with the Administrator on about 9:05 am. She confirmed that the resident is able to walk saying " she walks all over this building " . She confirmed the 1823 does not match the resident and

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that she receives assistance with med's .

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation of medication assistance including by mouth medications, eye drops, inhaler, and assistance by unlicensed staff, interview with staff regarding assistance with medications, and record review of the Medication Observation Record (MOR) the facility failed to provide appropriate assistance by unlicensed staff with for 1 of 1 resident (#15), assistance with by mouth medications for 4 of 4 residents (#11, #12, #13, and #15), assistance with eye medication for 1 of 1 resident (#8) and assistance with an inhaler for 1 of 1 resident (#5) .

The findings are:

An observation of medication assistance was made on during the noon meal with Resident Assistant Med Tech Employee (B). All residents were assisted with their medications at their table in the dining .

Resident #11 was assisted with 5 mg one tablet by mouth (po) three times daily about 11:47 am on . Employee B approached the resident who was sitting with three other residents. She told the resident I am giving you your noon med's. She shook out four pills into the cap of the pill bottle. She then directed the resident to take out one pill from the cap. The label was not read to the resident.

Resident #12 was assisted with 25-100 mg one tablet po three times daily on about 11:52 am by Employee B. She took the medication bottle and the MOR to the residents table where she was eating with three other residents. She showed the bottle to the resident, she then shook 2 pills from the bottle into the cap, and asked the resident to pick up one.

Employee B assisted Resident #13 with his medications on about 11:59 am. He was assisted with 50 mg one tablet po three times daily and 300 mg one cap po three times daily. Employee B approached Resident #13 at his table and told him in a low tone that she had his . She put the into the cap of the bottle and asked the resident to pick up one. She then did the same with the without identifying the medication.

Resident #5 was assisted with 20 mcg/100 mcg inhale one puff four times daily as needed about 12:05 pm on by Employee B. She took the inhaler to her table where she is already eating with two other residents. The Med tech shook the container and handed it to the resident. She then instructed her to put into her mouth , inhale as she pushed the gray button on the inhaler. The resident completed the instructions.

On about 12:08 pm Resident # 8 was assisted with his 0.15% gel both eyes daily twice daily by Employee B. Employee B approached Resident 8 and told him she had his eye medication after she had

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washed her hands and donned gloves. The resident stopped eating his meal and leaned back his head. Employee B then put the gel into the right eye.

On about 9:27 am Employee B was asked about assistance with medications. She stated, " I did not tell them what medication they were taking because it was in the dining other residents. Yes, my training says I am supposed to read the label " . She was asked how she would feel if a resident was sitting at her table while she was eating and they were given eye drops. She stated, "I would not like to see that while I was eating " .

Resident #15 was assisted with her oral medication 40 mg one cap by mouth 30 minutes before meals and Levimir Flex pen 100 units/injection 34 units daily on about 6:05 am by Resident Assistant Med Tech (Employee D). Employee D entered the resident's poured the pill into her hand. The resident took the pill. Employee D then dialed the Levimir flexpen to 30 units. The resident stated, " Most of the time I dial it " . The resident checked the dose, then applied the needle and injected herself into the abdomen.

An interview was conducted with Employee D on about 6:12 am. She was asked if she dialed the on the pen daily and she stated, " I always dial it for her even though she says she can dial it " . She was asked if she read the labels for medications to residents. She stated, " Yes I do " . She was asked if she read the label for Resident #15. She confirmed she did not read the label for her.

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on observation of medication assistance, staff interview and facility record review the facility failed to have the current health care provider for 1 of 1 resident #8 and to have the name, strength , and directions for use of each medication for 1 of 1 resident #5.

The findings are:

Resident #5 was observed to be assisted with 20 mcg/100 mcg inhale one puff four times daily as needed on about 12:05 pm. The MOR (medication observation record) was observed for the order. could not be found on the MOR.

An interview was conducted with the Resident Care Coordinator Employee E on about 9:44 am. She was asked to indicate on the MOR where the medication could be found. She stated, " No it is not there " . Then she said " It is the one that says aerosol inhalation take two puffs daily " . She was asked " Does this match the label on the " . She stated, "No" .

On about 12:08 pm Resident # 8 was assisted with his 0.15% gel both eyes daily twice daily according to the label by Employee B. Employee B approached Resident 8 and told him she had his eye medication after she had washed her hands and donned gloves. The resident stopped eating his meal and

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leaned back his head. Employee B then put the gel into the right eye.

Resident #8's MOR was reviewed and indicates was restarted on . Employee B was asked about the prescription for the since the MOR reads instill one drop four times daily and does not match the label on about 12:15 pm. She stated, "I cannot find the right prescription. I will call the doctor and ask them to fax it to us. On about 2:30 pm Employee E handed this surveyor a prescription that is dated for 0.15% gel instill in affected eye 5 times daily. Employee E confirmed the order was written on and verified that a new order is needed to verify how the doctor wants this medication given.

During further review of the MOR on it was observed that there was not a physician listed on 4 of the 5 pages of the MOR. Employee E was asked about the physician and MOR on about 6:58 am. She stated, " That is no longer his doctor " . She confirmed the MOR does not list Resident #8's current doctor with his phone number.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation of stored medications in the resident care coordinator's (RCC) office and staff interview the facility failed to dispose of abandoned medications within 30 days of discharge for 1 of 1 resident #16.

The findings are:

On about 2:45 pm while checking medication storage, two bottles of medication were found for resident #16 in a locked cabinet in the RCC's office. The RCC, Employee E was asked when the resident was discharged. She stated, " She was discharged on " . She confirmed the medications were : / 5-500 mg take one tablet by mouth twice daily 11 pills, and 30 mg ER tabs 16 pills left. Employee E then stated, " The administrator is responsible for destroying medications when residents have been discharged " .

An interview was conducted with the Administrator on about 3:00 pm. The administrator was asked how often medications were destroyed. She stated, " When we get a big batch of drugs about every month or so " . She was then asked about resident #16's medications. She stated , " She was discharged to long term care on . I destroyed all her other medications I guess Employee E missed giving those to me " .

Class III

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0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation of medication assistance, staff interview and resident record review the facility failed to have appropriate change of direction orders for 2 of 6 residents (#8, #15) and a current order for medication for 1 of 6 resident's observed for medication assistance (#5).

The findings are:

Resident #5 was assisted with 20 mcg/100 mcg inhale one puff four times daily as needed about 12:05 pm on by Employee B. She took the inhaler to the table where she is already eating with two other residents. The Med tech shook the container and handed it to the resident. She then instructed her to put into her mouth, inhale as she pushed the gray button on the inhaler. The resident completed the instructions.

An interview was conducted with the resident care coordinator (RCC) Employee E on about 9:44 am. She was asked to indicate on the MOR where the medication could be found. She stated, " No it is not there ". Then she said " It is the one that says aerosol inhalation take two puffs daily ". She was asked " Does this match the label on the ". She stated, " No ". She was asked to find an order to verify the orders but none could be found.

On about 12:08 pm Resident # 8 was assisted with his 0.15% gel both eyes daily twice daily according to the label by Employee B. Employee B approached Resident 8 and told him she had his eye medication after she had washed her hands and donned gloves. The resident stopped eating his meal and leaned back his head. Employee B then put the gel into the right eye.

Resident #8 ' s MOR was reviewed and indicates was restarted on . Employee B was asked about the prescription for the since the MOR reads instill one drop four times daily and does not match the label listed above on about 12:15 pm. She stated, " I cannot find the right prescription. I will call the doctor and asked them to fax it to us. On about 2:30 pm Employee E handed this surveyor a prescription that is dated for 0.15% gel instill in affected eye 5 times daily. Employee E confirmed the order was written on and verified that a new order is needed to verify how the doctor wants this medication given.

Resident #15 was assisted with her oral medication 40 mg one cap by mouth 30 minutes before meals and Levimir Flex pen 100 units/injection 34 units daily on about 6:05 am by Resident Assistant Med Tech (Employee D). Employee D entered the resident's poured the pill into her hand. The resident took the pill. Employee D then dialed the Levimir flexpen to 30 units. The resident stated, " Most of the time I dial it " . The resident checked the dose, then applied the needle and injected herself into the abdomen.

On about 6:26 am Employee E was asked to confirm an order to change the dose of Levimir from 34 units to 30 units. She confirmed there was no order in the record. About 8:53 am on this surveyor was

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given a physician's note indicating the was reduced to 30 units. Employee E confirmed it had been faxed this am and had not been in the resident's file.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on staff interview and record review the facility failed to ensure that 3 of 4 sampled employees completed the Affidavit of Compliance with the Background Screenings in their personnel files. (Employee #A, #C and #D)

The Findings:

A record review was conducted of four sampled employees during the biennial survey and the following was found:
1. Employee #A was hired on with eligible status. There was no Affidavit of Compliance with Background Screening found in the personnel file.

2. Employee #C was hired on with eligible status. There was no Affidavit of Compliance with Background Screening found in the personnel file.

3. Employee #D was hired on with eligible status. There was no Affidavit of Compliance with Background Screening found in the personnel file.

On at approximately 10:30 a.m, an interview was conducted with the Resident Care Coordinator. (RCC) The RCC confirmed that she could not provide the Affidavit of Compliance for the three employees. The RCC reported that she would ensure that all employees of the facility will complete the Affidavits.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Summer's Landing
615 Florida Avenue
Lynn Haven, FL 32444

Dear Administrator:

This letter reports the findings of a state licensure 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 me at 850-412-4540.

Sincerely,

Patricia McLittle, RN

for Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

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