

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 09/24/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11966134	(X3) DATE SURVEY COMPLETED 08/28/2013
NAME OF PROVIDER OR SUPPLIER Good Samaritan Care Center, Al	STREET ADDRESS, CITY, STATE, ZIP CODE 6 Reston Place Palm Coast, FL 32164	
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= E
 St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures 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= D
 St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
 St - A - 0092 - 58a-5.020(1) Fac - Food Service - General Responsibilities S-S= D
 St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= F
 St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D
 St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
 St - A - 0164 - 58a-5.024(4) Fac - Records - Inspection Availability S-S= E
 St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= D

Specific Tag Findings:

0000-Initial Comments

A biennial licensure survey was conducted at Good Samaritan Care Center on , 2013. Deficiencies were identified.

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

Based on a review of resident records, and interview with the Administrator, the facility failed to obtain updated, accurate resident health assessments (AHCA form 8523) for 2 of 2 sampled residents who had a significant change in their medical condition (Residents #1 and #5).

The findings include:

1. A record review conducted for Resident #1 found she was admitted 12/1/11 and was . The resident health assessment, dated , noted a diagnosis of , and . A resident weight record, which was not available at the time of survey, was faxed into the field office on . Review of the weight record reflected that on admission, Resident #1 weighed 155(lbs) pounds. The following weights were noted on the weight record:

2012- 154
 2012- 157
 2013- 154
 2013- 140
 2013- 140
 2013- 130
 2013- 132

This reflected a 9% reduction in weight between , and , 2013, and a 14% reduction in weight between , and , 2013. There was no indication the physician was contacted, or that the resident was re-assessed, following significant weight loss.

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2. During a facility tour at 8:15 am on _____, Resident #5 was observed in her hospital bed in _____. She did not respond to this writer, received continuous _____ through a nasal cannula, and had a _____ in _____ place. The Administrator explained the resident received hospice services, and was eminent.

A record review conducted for Resident #5 found she was admitted _____, and was _____ A resident health assessment dated _____ noted diagnoses including _____ and status post hip replacement. She required total assistance with activities of daily living, and was not bedridden. The assessment failed to indicate whether or not the resident was appropriate for placement in an assisted living facility. Further record review found hospice services commenced in _____ of 2012. No additional health assessment could be located in the resident record.

An interview was conducted with the Administrator at 11:15 am on _____. She stated acknowledged the omitted information on Resident #5's health assessment, and that a new health assessment was required when residents had a significant change in condition.

Class III

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

Based on observation and interview with staff, the facility failed to ensure appropriate health care consistent with recognized community standards, by neglecting to follow proper _____ control procedures during assistance with medication administration for 3 of 3 sampled residents (Residents #1, #2 and #6) and 1 unsampled resident (Resident #3). In addition, the facility failed to ensure the right to privacy for 1 of 5 residents (Resident #5), by installing a video monitoring system in his _____.

The findings include:

1. Observation of assistance with self-administration of medications commenced at 8:45 am on _____. Without washing or sanitizing her hands, Employee #1 (a caregiver) poured the following medications into her hand one pill at a time, and then placed each on the placemat in front of Resident #6; metoprolol _____ fish oil, _____, and _____. The resident took her pills independently. Employee #1 retrieved a pen, and documented each medication taken on the medication observation record (MOR).

At 8:50 am on _____, without washing or sanitizing her hands, she proceeded directly to Resident #3, who received day care services from the facility. Employee #1 dispensed the following medications, one tablet at a time, into her bare hand and then placed them on the table in front of the visiting resident: fish oil (2 capsules), _____, C, stool softeners (2) and extra strength _____. Without washing her hands, Employee #1 began setting the dining table with clean napkins, cups and saucers, and utensils.

At 8:55 am on _____, Resident #2 came to the table. Without washing or sanitizing her hands, Employee #1 dispensed the following pills into her bare hand, and placed them on the napkin in front of the resident; _____, pantaprozol, sodium _____, and a probiotic. She took her pen and documented all medications taken by this resident on the MOR.

At 10:07 am on _____, resident #1 came to the kitchen table. Without washing or sanitizing her hands, the

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employee repeated the same procedure. She dispensed all medications into her bare hands, and placed the following on the placemat in front of Resident #1; navartis, coQ10, tektuma, and a probiotic. The resident took her medications one at a time.

An interview was conducted with the employee at 10:15 am. She acknowledged she did not wash or sanitize her hands prior to assistance with the medications, or between residents. She was not aware she should not touch resident's medications with her bare hands.

2. An observation of Resident #4's 10:55 am found an active video monitoring camera mounted inside the door, near the ceiling. It pointed toward the resident's bed. Other cameras were located about the facility, including in the dining in other resident. A small television monitor was set up in the dining

At 11:00 am, the Administrator demonstrated the facility's video monitoring system. She turned on the monitor, and selected several resident one at a time. Black screens appeared for all residents but Resident #4's. A clear picture of the resident's bed, and bedside easy chair, came across the screen.

A interview conducted with the Administrator at 11:00 am on found the camera was activated in Resident #4's he was "new" to the facility. She and the Nurse Practitioner wanted to "learn more about him". They were also concerned about his safety. She explained the camera was monitored on the night shift only, and that other cameras in were no longer active. The sensors in other simply acted as motion detectors on the overnight shift, and would sound an alarm if a resident was moving about the. She acknowledged the camera in Resident #4's an infringement on his privacy, however thought that since the family consented to it, this was not an issue.

Class III

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

Based on an observation of the refrigerator and interview with the Administrator, the facility failed to secure over the counter medications requiring refrigeration, for 2 of 2 sampled residents (Residents #1 and #2).

The findings include:

An observation of the kitchen refrigerator at 10:25 am found two (2) over the counter bottles of acidophilus, (a probiotic), labeled for Resident #1 and #2 respectively. Each were located inside the clear plastic butter storage shelf, and were not locked within the refrigerator. Inspection of the exterior of the refrigerator door found no locking mechanism in place.

An interview was conducted with the Administrator at 10:30 am on. She acknowledged the medications were required to be locked up, and stated she would lock them up immediately.

Class III

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

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Based on observation, resident record review and interview with the Administrator, the facility failed to obtain a written medication order from the resident's health care provider for 1 of 3 sampled residents (Resident #6) who received assistance with self-administration of medication.

The findings include:

Observation of assistance with the self-administration of medication was conducted at 8:45 am on Resident #6 received the following prescription medications: _____ 50 milligrams, _____ meq, and _____ 20 milligrams.

A review of the MOR for Resident #6 found her _____ 20 mg was taken every day at 8:00 am. Further record review found there was no written physician's order for the use of the _____ for Resident #6.

An interview was conducted with the Administrator at 12:50 pm on _____. She acknowledged the missing order for _____, and stated she did not realize a written order was required. She said she thought the medication label was sufficient.

Class III

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

Based on observation, employee record review, and interview with the Administrator, the facility failed to ensure the required 1 hour of _____ control in-training prior to the provision of care to the residents for 1 of 2 sampled employees (Employee #1).

The findings include:

Observation of Employee #1 between 8:30 am and 1:00 pm on _____ found she provided services to residents including personal care, meal preparation and assistance with self-administration of medications.

A review of Employee #1's personnel file found she had worked for the facility since approximately _____ of 2012. There was no documentation the employee had received the required 1 hour of training in _____ control and facility sanitation procedures prior to the provision of personal care to the residents.

An interview was conducted with the Administrator at 1:20 pm on _____. She insisted the employee was actually a volunteer until recently, and said she did not realize she needed all required trainings as a volunteer. She acknowledged Employee #1 performed staff duties, including personal care.

Class III

0092-Food Service - General Responsibilities 58A-5.020(1) FAC

Based on observation of the resident refrigerator, and interview with the Administrator, the facility failed to ensure leftover food was stored in a safe and sanitary manner and in accordance with the 2009 food code.

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The findings include:

An observation of the resident refrigerator at 1:00 pm on found the following: a large uncovered metal bowl containing a quarter of a watermelon, a small uncovered ceramic bowl containing one half of a cooked yam, and an uncovered glass container of fruit suspended in an clear liquid, and a partially eaten, foil-covered lemon pie. None of the food items were labeled with the contents, the date of preparation, or a use-by date. It was unclear how long the food had been in the refrigerator, or if it was intended to be served to the residents.

Review of the 2009 food code, section 3-302.11 (Packaged and Unpackaged Food - Separation, Packaging, and Segregation) gives the following instructions for safe storage of foods:

(A) Food shall be protected from cross contamination by:

(4) Except as specified under Subparagraph 3-501.15(B)(2) and in ¶ (B) of this section, storing the food in packages, covered containers, or wrappings.

An interview was conducted with the Administrator at 1:10 pm on . She stated the fruit had been served this morning at breakfast. She acknowledged all items should have been properly covered before storing in the refrigerator. She agreed that without a label indicating a preparation or use-by date, it was not possible to determine how long the partially eaten food had been in the refrigerator.

Class III

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

Based on observation and interview with the Administrator, the facility failed to ensure a safe living environment which was free from hazards by neglecting to ensure the safe storage of canisters in 1 of 5 resident

The findings include:

During a tour of the facility at 8:15 am on was observed to have 6 canisters sitting on the floor just behind the . They were not in an approved rack, nor were they affixed to the wall.

The 1999 edition of the NPFA (National Fire Protection Association) 99 Health Care Facilities Handbook specifies containers must be kept in place using "stable racks or fastenings to protect them from falling."

An interview was conducted with the Administrator at 1:00 pm on . She stated hospice managed the that was stored in . She did not realize it was required to be secured in order to be stored safely.

Class III

0160-Records - Facility 58A-5.024(1) FAC

Based on a review of facility records, and interview with the Administrator, the facility failed to maintain an accurate admission and discharge log which reflected actual admission dates for 2 of 2 sampled residents

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(Residents #1 and #2).

The findings include:

A review of the admission and discharge log found Resident #1 had a documented admission date of "2011". Further review found the log reflected an admission date of "2013" for Resident #2. There was no actual day of admission noted on the log for either resident.

An interview was conducted with the Administrator at 10:00 am on She acknowledged the missing dates, and stated she would make needed corrections to the log.

Class III

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

Based on observation, employee record review, and interview with the Administrator, the facility failed to ensure the personnel file for 1 of 2 sampled employees (Employee #1) contained required documentation of compliance with all required staff training.

The findings include:

Observation of Employee #1 between 8:30 am and 1:00 pm on found she provided services to residents including personal care, meal preparation and assistance with self-administration of medications.

A review of Employee #1's personnel file found she had worked for the facility since approximately of 2012. There was no documentation the employee had received the required 1 hour of training in control and facility sanitation procedures prior to the provision of personal care to the residents.

An interview was conducted with the Administrator at 1:20 pm on She acknowledged Employee #1 performed staff duties, including personal care. She said because the employee had been a volunteer until recently, she did not realize she needed the required training.

Class III

0164-Records - Inspection Availability 58A-5.024(4) FAC

Based on a review of resident records, and interview with the Administrator, the facility failed to ensure resident records were available for inspection by agency staff for 2 of 3 sampled residents who received assistance with self-administration of medication during the survey (Residents #1 and #2).

The findings include:

On at 8:55 am, Resident #2 was observed to receive assistance with self-administration of medication from facility staff. According to the medication labels, she took the following prescription medications: 40 milligram (mg), 1 every day for 90 days (started 1 mg, take 1/2 tab daily, and pantaprozol 40 mg, 1 daily.

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At 10:07 am on _____ Resident #1 came to the kitchen table for assistance with self-administration of medication. Per the medication labels, she took _____ 10 mg, _____ 25 mg, navartis 300 mg, and tektura 300 mg.

Record reviews for Resident #1 and #2 found there were no signed physician's orders for prescription medication, and the Resident Health Assessments had been removed from the records during the survey.

An interview was conducted with the Administrator at 12:50 pm on _____. She stated both Resident #1's and #2's 1823s, which included current prescriptions, had been removed from the facility by family members, and were not available for review at the time of survey.

Class III

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

Based on observation, employee record review, and interview with the Administrator, the facility failed to obtain the required level II background clearance for 1 of 2 sampled employees (Employee #1) who provided care and services directly to the residents.

The findings include:

Observation of Employee #1 between 8:30 am and 1:00 pm on _____ found she provided services to residents including personal care, meal preparation and assistance with self-administration of medications.

A review of Employee #1's personnel file found she had worked for the facility since approximately _____ of 2012. There was no documentation of level II background clearance for this employee.

During an interview with the Administrator at 1:20 pm on _____, she insisted the employee was actually a volunteer until recently. She had become a paid employee of the facility in _____ 2013. The Administrator did not realize Employee #1 needed a level II background screening. Employee #1 was scheduled to submit her fingerprints for background clearance on _____ 2013.

Unclassified



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

"CORRECTED COPY"

Administrator
Good Samaritan Care Center, Al
6 Reston Place
Palm Coast, FL 32164

Dear Administrator:

This letter reports the findings of a state biennial licensure survey that was conducted on 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 2013 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at

Sincerely,

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

KW/sm
Enclosure

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