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List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living 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 - 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 - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced Assisted Living Facility biennial standard relicensure survey was conducted on 2013. The Eden Inn, had deficiencies found at the time of the visit.

0007-Admissions - Criteria 58A-5.0181(1) FAC

Based on interviews and record review, the facility failed to provide and obtain the required written informed consent related to unlicensed staff assisting residents with self-administration of medications from residents or their legal representatives, for 2 out of 2 sampled residents (Resident #4 and #7).

The findings include:

1. Review of Resident #7 ' s record and resident agreement signed revealed no written informed consent document was available.

2. During Resident Record Review for Resident #4 on a signed Informed Consent Form was not found within the Resident's record.

At approximately 1:00 PM, an interview is conducted with the Administrator regarding the missing Informed Consent Form. The Administrator states there is not an Informed Consent Form for Resident #4. He also states the Informed Consent Form is not included with the admission packet.

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

Based on interviews and record review, the facility failed to ensure resident medical examinations (AHCA Form 1823) were timely, complete and accurate for 3 out of 3 sampled residents (Resident #1, #3 and #4).

The findings include:

1. Resident #1 was admitted to the facility on . Review of her AHCA Form 1823 (health assessment) revealed diagnoses including: a left above-the-knee amputation and a right below-the-knee amputation, Chronic Kidney . High . and . Further review of the form revealed the following concerns:

a. The sections titled Physical or Sensory Limitations and Special Precautions were left blank when the resident is a double-amputee and is legally .

b. The section titled . Service Requirements disclosed, "continue with therapies" but no other related information was provided on the form.

c. Section 1, Item A. documented she required assistance with ambulation but did not include the resident has no lower legs or feet to ambulate with or provide related instructions.

d. Section 1, Item A. calls for supervision or assistance with all of her activities of daily living but failed to specify the extent (the number of staff required) and type of supervision or assistance required in the Comments sections.

e. Section 2, Item A. calls for supervision with preparing meals and shopping but failed to specify the extent and type of assistance required in the Comments sections.

f. Section 2, Item B. is not answered as to whether the resident is able to self-administer medications, needs assistance with self-administration of medications (by unlicensed staff), or needs administration of medications (by a licensed or registered nurse).

g. Page 4 disclosed "Medical certification is incomplete without the following information:". The health care provider did not document his medical license number, address and telephone number, nor did he document the date of the examination.

These concerns were discussed with and acknowledged by the Administrator on at 3:32 PM.

2. Resident #3 was admitted to the facility on . Review of his medical examination form (health assessment) revealed the following concerns:

a. The section titled Special Precautions was left blank.

b. Section 1, Item A. calls for supervision and assistance with bathing but failed to specify the extent

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and type of supervision or assistance required in the Comments sections.

c. Section 2, Item A. calls for assistance with preparing meals, shopping, making phone calls, and handling personal and financial affairs, but failed to specify the extent and type of assistance required in the Comments sections.

d. The form was certified by a Doctor of Osteopathy on . . . 90 days prior to the resident's admission to this facility.

These concerns were discussed with and acknowledged by the Administrator on . . . at 2:30 PM.

3. Review of AHCA Form 1823 for Resident #4 revealed Section 2b was not completed by the Resident's physician. Section 2b specifies if the Resident needs help with taking his or her medications and indicates the type of help the resident requires, med assistance or med administration.

On . . . . at approximately 4:50 PM, the missing notation on Resident #4's Health Assessment (Form 1823) was brought to the attention of the Administrator, and he acknowledged the form was not complete.

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

Based on observations, interviews and record review, the facility failed to supervise and assist residents with activities of daily living related to . . . for 2 out of 5 sampled residents interviewed (Resident #2 and #6); the residents were observed with excessively long and soiled fingernails.

The findings include:

1. Resident #6 was observed during an interview conducted . . . at 10:24 AM. His fingernails were excessively long, the nails on his right hand were visibly soiled. When asked about them, he stated, "It's time to cut them." He made an embarrassed facial expression when the soiled fingernails were pointed out to him. Review of his most recent AHCA Form 1823 (medical examination) conducted . . . documented he required assistance with . . .

2. Resident #2 was observed during an interview conducted . . . at 11:35 AM. His fingernails were excessively long, a few of the fingernails were visibly soiled. When asked about them, he stated, "I'm a little

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embarrassed, I do not usually let them get this long." Review of his most recent medical examination conducted documented he required supervision with

This was discussed with and acknowledged by the Administrator on at 1:37 PM. He stated he would take care of it.

Class III

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

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who assisted residents with self-administration of medications followed required standards of practice for 2 out of 2 sampled residents and two randomly observed residents (Resident #1, #3, #6 and #7).

The findings include:

1. In an interview conducted at 1:10 PM, the Administrator, an unlicensed staff member, revealed:

A. He performs or glucose testing, for Resident #3 every morning. He stated he has a glucose testing unit available for use by multiple residents; he cleans the unit with an preparation swab between uses and stores it in the medication cabinet. The Administrator also stated Resident #3 has an order for injections based on a sliding scale but he has not had to provide injections yet because the glucose tests results were never over 150.

i. Review of Resident #3's and 2013 MORs documented the Administrator performed the glucose testing as stated. glucose testing is considered medication administration and as such, unlicensed staff are prohibited from performing glucose testing.

ii. Preparation of syringes for injection or the administration of medications by any injectable route are considered medication administration and unlicensed staff are prohibited from performing any part of this task.

iii. Review of Resident #3's record revealed a written health care provider's order dated that called for glucose testing three times daily right before meals, and if needed, inject coverage, the amount based on the sugar test results: a result of 0 to 100 would receive no coverage, a result of 101 to 200 would receive 4 units of coverage, and so on. This task is considered medication administration and as such, unlicensed staff are prohibited

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from the preparation of syringes for injection and the administration of medications through any injectable route. While the record disclosed the resident did not receive any injections from the Administrator, the Administrator stated it was his intent was to do so if necessary.

The Administrator did not follow the written order and applied his own sliding scale which resulted in the resident not receiving the prescribed coverage when his glucose levels called for coverage in 12 out of 33 possible opportunities for coverage. In addition, the test results were recorded on the MORs under an entry that read "Lantus inject 15 units every morning".

Further, the Administrator did not take steps to assist the resident to access needed health care services from qualified persons, a licensed or registered nurse. Associated but separate concerns were cited under A027 and A056 herein related to not assisting the resident to access appropriate health care services and for changing instructions for a prescribed medication without first obtaining a written health care provider's order.

B. In an interview conducted at 1:10 PM, the Administrator stated Resident #1 is legally and conducts her own glucose tests using an audio glucose meter. She reports the results to him, he dials her and Lantus pens" to the desired settings, and gives them to her for self-administration. In an interview conducted at 9:39 AM, Resident #1 confirmed this was the daily routine. This practice is similar to when doses are based on sugar levels, or "sliding scale".

i. Review of her and 2013 MORs documented orders for: Lantus 24 units injected every morning, the doses on the MORs were marked "self" ; and N 20 units injected every morning and 10 units inject every evening, only the morning doses on the MORs were marked "self", the evening doses were left blank.

Only one written HCP order related to a "sliding scale" was dated and read, for sliding scale AC /HS Needs 30 units average daily # 3 month supply".

Further review of her MORs and other records revealed no evidence the Administrator recorded the resident's glucose test results.

ii. Her AHCA Form 1823 (medical examination) was not dated. The form did not specify if she was able to self-administer any of her medications, if she required assistance with self-administration of any of her medications, or if she required administration of medications by a licensed or registered nurse. More specifically, the examination did not specify if she was able to self-administer her injectable or if she required administration of her injectable by a licensed or registered nurse. This task is considered medication administration and as such, unlicensed staff are prohibited from preparing syringes for injection; this task may only be performed by the resident if deemed by a health care provider to do so, or by a licensed or registered nurse.

2. The Administrator was observed assisting Residents #1, #6, and #7 with self-administration of medications on beginning at 5:33 PM. For two of the three residents observed, he did not bring the medication containers and the resident together before pulling the medications nor did he read the labels to the residents or tell them what medications they were about to take. After giving

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the first resident her pill cup, he walked away from her without confirming she had swallowed the medication. For the third resident, he did not either read the label to the resident or tell him what medication he was about to take. For all three residents, he was observed to tell the residents, "Here is your medicine".

Confidential resident interviews (CRI) with three alert and oriented residents revealed:

A. CRI#1 stated, "[The Administrator] does not tell them the names of the medications or what they are for; he gives them in a pill cup and usually does not stay to make sure I took them, he is too busy, we are adults here, we know to take our pills."

B. CRI#2 stated, "I get my pills in a cup every day, I don't get told what, he puts the pill cup on the table."

C. CRI#3 stated, "I get my pills every morning and every evening in a pill cup, [the Administrator] puts it on my table and walks away. I take them and put the cup on my plate and put the plate on the counter."

3. A small basket with medical supplies was observed at 2:45 PM. It was full of first aid and care supplies; it held several containers of prescribed care medications with prescription labels either worn or removed; some of the medication containers and supplies were worn and/or soiled. Contents of concern included:

A. Spray, 4 ounces, with an expiration date of

B. 2%, 60 GM tube

C. 1% Silver Cream, 25 GM tube

D. Cream 2.5%, 28 GM tube

E. Triple Ointment, 28.4 ounce tube

F. Silvasorb Gel, 44.4 ML tube

G. Triaminacinolone Cream, 8 ounce tube with an expiration date of

At that time, the Administrator identified the basket as "first aid and care supplies". He stated, "Some of the supplies were from prior residents." and, "These supplies cost money, what else am I supposed to do with this?" He was reminded it was prohibited to use prescription medications for anyone other than to whom it was prescribed.

These concerns were discussed with and acknowledged by the Administrator throughout the survey and at 4:11 PM.

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

Based on interviews and record review, the facility failed to maintain accurate medication observation records (MORs) as required for 3 out of 3 sampled residents (Resident #1, #3 and #7).

The findings include:

Review of the facility's medications system was conducted on beginning at 12:50 PM with the Administrator present. The following concerns were identified:

1. Review of Resident #1's records revealed she was admitted to the facility on with diagnoses including Chronic Kidney High and

a. Interviews conducted at 9:39 AM with the Resident and at 1:10 PM with the Administrator, revealed she was legally and conducted her own glucose tests using an audio glucose meter and reports the results to the Administrator. Review of her and 2013 MORs and other related records revealed no record showing the Administrator recorded any of the resident's glucose testing results.

b. The MORs entries for her and Lantus were marked "self" to indicate Resident #3 had self-administrated this medication although the Administrator stated he assisted Resident #1 with self-administration of the pens. Her AHCA Form 1823 (medical examination) did not specify if she was able to self-administer any of her medications, and did not specify if she was able to self-administer her inject her herself, or if it needed to be done by a licensed or registered nurse.

c. Her and 2013 MORs documented orders Lantus 24 units injected every morning; and N 20 units injected every morning and 10 units inject every evening. Review of her written health care provider orders revealed the following orders, none matched corresponding entries on the MORs:

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i. "Humulog for sliding scale AC /HS Needs 30 units average daily # 3 month supply"

ii. "Lantus #1 use 18 units QD"

iii. "Lantus 18 units daily AM #10 pen B&D needle #200"

2. Review of Resident #7's record and and 2013 MORs documented the following concerns:

a. These medications with conflicting or missing written HCP orders:

1) MOR read 50 MG to be taken every 8 hours as needed.Written HCP order dated read 50 MG to be taken every 8 hours . Medical examination dated read 50 MG to be taken every 8 hours as needed.

2) MOR read 20 MG to be taken at 9:00 AM and 9:00 PM. Written HCP order dated read 20 MG to be taken twice daily

3) MOR read to be taken twice daily. Written HCP order dated read to be taken daily. Medical examination dated read twice daily

4) MOR read 1 puff in each nostril daily. Written HCP order dated did not list sprays per dose or frequency of doses. Medical examination dated read 1 spray each nostril daily

b. Resident #7 was admitted to the facility on The Administrator had recorded medications received in on the MOR from through On and he recorded medications received in on the MOR also. In an interview conducted at 12:54 PM, the Administrator stated he had run out of blank MOR forms so he was using y's to record

3. Review of Resident #3's record and and 2013 MORs documented the following medications with conflicting or missing written HCP orders:

1) MOR read to be taken twice daily
Undated medical examination read to be taken daily, no evidence of written HCP order in resident's record

2) MOR read 10 MG to be taken daily
Undated medical examination read 5 MG to be taken daily, no evidence of written HCP order in resident's record

3) MOR read 22.3 MG/6.8 MG one drop each eye to be taken at bedtime
Undated medical examination read 1(illegible) and did not list number of drops in a dose or frequency of doses

4) Written HCP order dated read 7.5 MG to be taken daily

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MOR did not include this medication

These concerns were discussed and acknowledged by the Administrator throughout the medication system review process and at 4:11 PM.

Class III

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

Based on observations and interview, the facility failed to transfer or destroy medications as required when it was discontinued, abandoned or expired.

The findings include:

1. A small basket full of miscellaneous medical supplies was observed on at 2:45 PM. The Administrator identified the items below as medications belonging to residents discharged more than more than 60 days before that were intended for use for first aid and l care; he acknowledged some had expired.

a. Spray, 4 ounces, with an expiration date of

b. 2%, 60 GM tube

c. 1% Silver Cream, 25 GM tube

d. Cream 2.5%, 28 GM tube

e. Triple Ointment, 28.4 ounce tube

f. Silvasorb Gel, 44.4 ML tube

g. Triaminacinolone Cream, 8 ounce tube with an expiration date of

2. On at 2:40 PM, a half-empty bottle of with no indication to whom it was prescribed to was observed stored in the medication refrigerator. The Administrator, present at the time, stated he did not know who it belonged to or how long it had been there.

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

Based on interviews and record reviews, the facility failed to ensure unlicensed staff who assist residents with self-administration followed required standards of practice for3 out of 3 sampled residents (Resident #1, #3 and #7).

The findings include:

Medication systems review was conducted beginning at 12:50 PM with the Administrator present; the following concerns were identified:

1. Review of Resident #3's health assessment (AHCA Form 1823) (medical examination) dated documented pertinent diagnoses of and and needed assistance with self-administration of medications. Further record review conducted revealed the following concerns:

a. A written HCP order dated called for glucose testing three times daily right before meals, and if needed, inject coverage, the amount based on the sugar test results: a result of 0 to 100 would receive no coverage, a result of 101 to 200 would receive 4 units of coverage, and so on. In an interview conducted at 4:01 PM, the Administrator, an unlicensed staff member, stated Resident #3 has an order for injections based on a sliding scale but he has not had to provide injections yet because the glucose tests results were never over 150. He stated it was his intention to provide the injections if coverage was needed. The order called for 4 units of coverage if the glucose test result was over 100. The following list of glucose testing represents 12 opportunities since wherein 4 units of coverage was ordered but not received by the resident:

1) result was 101
2) result was 103
3) result was 104
4) result was 101
5) result was 103
6) result was 101
7) result was 102
8) result was 101
9) result was 101
10) result was 101
11) result was 101
12) result was 101

b. Resident #3's record documented written HCP consult notes dated that called for Lantus 15 units injected every morning. His and 2013 MORs documented the same order. There were no initials to indicate he received these prescribed medications. The entry on the MORs was used to record glucose testing results and coverage given. In an interview conducted at 1:10 PM,

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the Administrator had no explanation for why the medication was not received by the resident or why he was not assisted to obtain these services from a licensed or registered Nurse.

c. A written HCP order dated documented, use as directed #1 bottle". His and 2013 MORs documented, 100 unit/ml in sol, use as directed". There was no documentation giving specific directions for use. There were no initials on the MORs to indicate he received this prescribed medications. In an interview conducted at 1:10 PM, the Administrator had no explanation for why the medication was not received by the resident or why he was not assisted to obtain these services from a licensed or Registered Nurse as required.

2. Observation of and interview with Resident #1 on at 9:39 AM, revealed she is legally Review of Resident #1's AHCA Form 1823 (medical examination) which was not dated, did not specify if she was able to self-administer any of her medications, if she required assistance with self-administration of any of her medications, or if she required administration of medications by a licensed or Registered Nurse.

During the interview, she stated she conducts her own glucose tests using an audio glucose meter. She reports the results to the Administrator, he dials her and Lantus pens" to the desired settings and gives them to her for self-administration. The Administrator confirmed this information in an interview conducted at 1:10 PM.

Review of her and 2013 MORs documented orders for N 20 units injected every morning and 10 units inject every evening. Further record review revealed no written HCP order for this medication. The entry on the MORs makes no reference to if this legally resident can self-administer injections, needs assistance with self-administration, or needs licensed nurse administration for the injections. The morning doses are marked "self" to indicate the resident self-administered the medication, but all of the evening doses were not initialed or otherwise marked, indicating she did not receive the evening doses as ordered.

3. The medication system review process revealed the following medications were being taken by Resident #3 but there were no written HCP orders for the medications:

a. Medication container label read N inject 20 units every AM and 10 units every evening
MOR read N inject 20 units every AM and 10 units every evening
Not on undated medical examination, no evidence of written HCP order in resident's record

b. Medication container label read 25 MG 1 capsule by mouth at bedtime as needed for itching
MOR read 25 MG 1 capsule by mouth at bedtime as needed for itching
Not on undated medical examination, no evidence of written HCP order in resident's record
c. Medication container label read Flexeril 5 MG 1 tablet by mouth at bedtime as needed for neck pain or stiffness
MOR read Flexeril 5 MG 1 tablet by mouth at bedtime as needed for neck pain or stiffness
Not on undated medical examination, no evidence of written HCP order in resident's record

4. The medication system review process revealed the following medications had conflicting or missing written

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HCP orders and should have been clarified with the HCP by facility staff:

a. Related to Resident #7:
(1) Medication container label read to be taken 3 times daily as needed.
MOR read to be taken every 8 hours as needed.
Written HCP order dated read to be taken every 8 hours
AHCA Form 1823 (medical examination) dated read to be taken every 8 hours as needed.
An "alert" label must be placed on the medication container if the order changes.
(2) Medication container label read 10 milligrams (MG) 2 tablets to be taken before breakfast and dinner.
MOR read 20 MG to be taken at 9:00 AM and 9:00 PM.
Written HCP order dated read 20 MG to be taken twice daily.
An "alert" label must be placed on the medication container if the order changes
(3) Medication container label read C with no instructions for use.
MOR read to be taken twice daily
Written HCP order dated read to be taken daily.
Medical examination dated read twice daily.
(4) Medication container label read 1 puff in each nostril daily.
MOR read 1 puff in each nostril daily
Written HCP order dated did not list number of sprays in a dose or frequency of doses.
Medical examination dated read 1 spray each nostril daily
An "alert" label must be placed on the medication container if the order changes

b. Related to Resident #3:
(1) Medication container label read to be taken twice daily.
MOR read to be taken twice daily.
Undated medical examination read to be taken daily, no evidence of written HCP order in resident ' s record.
(2) Medication container label read 10 MG to be taken daily
MOR read 10 MG to be taken daily.
Undated medical examination read 5 MG to be taken daily, no evidence of written HCP order in resident ' s record.
(3) Medication container label read 22.3 MG/6.8 MG one drop each eye to be taken at bedtime.
MOR read 22.3 MG/6.8 MG one drop each eye to be taken at bedtime
Undated medical examination read 1(illegible) and did not list number of drops in a dose or frequency of doses.
An "alert" label must be placed on the medication container if the order changes

5. The medication system review process revealed Resident #7 was taking the following a medication for which written HCP orders had changed but no "alert" label was affixed to the medication container as required:
a. Medication container label read Busipirone to be taken every 8 hours
b. MOR read to be taken three times daily
c. Written HCP order dated read to be taken three times daily

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6. During inspection of medication storage, a vial of partially used, unidentified was observed in storage; the Administrator stated he did not know who it belonged to or how long it had been there.

These concerns were discussed with and acknowledged by the Administrator throughout the survey and at 4:11 PM.

Class III

0083-Training - First Aid and 58A-5.0191(4) FAC

Based on staff interview and employee record review, the facility failed to have a staff member who has completed courses in First Aid and holds a currently valid card documenting completion of such training in the facility at all times, for 3 out of 3 employees whose employee records were reviewed (Employees A, B, and C).

The findings include:

During employee record review for Employees A, B, and C, it was noted there were no current, valid First Aid Training documentation in any of the employee files reviewed. The latest First Aid Training card found in each employee's file had expired of 2011.

Interview was conducted with the Administrator on at 4:55 PM. He was informed of the missing documentation which confirmed staff had current, valid First Aid Training. The Administrator stated he believed all staff had taken the First Aid Training since of 2011. The opportunity was provided to the Administrator to produce a current, valid First Aid card/certificate for Employee A, B, and/or C. As of 5:32 PM, the Administrator had not provided the missing documentation.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966286	**08/02/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Eden Inn (the)	**4064 Sw 51st Street Davie, FL 33314**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. . . . . 10 , 2013

Administrator
Eden Inn (The)
4064 SW 51st Street
Davie, FL 33314

Re: Biennial Standard Relicensure

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 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/jw
Enclosure
XG90

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