

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 10/17/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11964669	(X3) DATE SURVEY COMPLETED 09/23/2013
NAME OF PROVIDER OR SUPPLIER Arden Courts Of Seminole	STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Antilles Street, North Seminole, FL 33776	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
 St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D
 St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
 St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D
 St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D

Specific Tag Findings:

0000-Initial Comments

A biennial state licensure survey with limited nursing services (LNS) was conducted on , in conjunction with a complaint survey, CCR# 2013008179.

Arden Courts of Seminole, assisted living facility, had deficiencies at the time of the visit.

0053-Medication - Administration 58A-5.0185(4) FAC

Based on observation, interview, and record review, the facility staff failed to correctly prepare and administer medications to 1 (Resident #14) of 6 residents sampled during the medication pass.

Findings include:

Observation of the medication pass on at approximately 1:20pm revealed that Staff F prepared Resident #14's medications by crushing them and putting them in pudding. The resident was observed taking the medication from a spoon.

Review of the medication label and machine-generated medication observation records (MORs) for Resident #14 revealed that one of the medications that the resident was given was pa-Levo 50-200 SA tab, take 1/2 tab orally daily at 2PM. The MORs revealed that the pa-Levo tablet (treats Parkinson's) was not supposed to be chewed or crushed.

Interview with Staff F on at approximately 1:20pm revealed that the medications were crushed because he can not swallow them whole. When the surveyor pointed out the bottom of the MORs that this should not be crushed pa-Levo). She stated she will contact the doctor because he cannot swallow it otherwise.

Class III

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

Based on record reviews and interview, the facility failed to ensure that medication observation records (MORs) were completed accurately for 2 (Residents #11 and #14) of 6 residents observed during the medication pass.

Findings include:

Review of Resident #11's MORs revealed that he had a medication order for 0.25mg (treats agitation). take 1 tablet by mouth 3 times daily. There were 2 empty spaces next to the medication that had not been initialed to indicate that it had been given to the resident. The dates for the spaces were and . There was also nothing written on the back of the MORs to indicate if the medication was or was not given.

Interview with Staff F, a licensed practical nurse, on at approximately 12:40pm revealed that she did not know why the medication was not signed.

Review of Resident #14's MORs revealed that he had a medication order for pa-Levo 50-200 SA tab (treats Parkinson's) take 1/2 tab orally daily at 2pm. There was a blank space next to the medication on . There was no indication on the back of the MORs why the medication was not initialed.

In the interview with the resident services coordinator on at approximately 5:30pm, she acknowledged that the MORs should have been signed and/or indicated why the medication was not given.

Class III

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

Based on record review and interview, two of four direct care staff sampled (C; D) had not received all required training within the first 30 days of employment.

Findings include:

A personnel file review during the survey revealed that Staff C (hired) had not received the 3 hour training in providing assistance with ADLs and resident behavior and needs, while Staff D (hired) did not have any documentation verifying she had been trained in safe food handling practices.

Interview with the resident services coordinator at approximately 1:15pm on confirmed that these employees were missing these respective trainings.

Class III

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

Based on record review and interview, the facility did not ensure that at least one (1) of three AM staff sampled (E) held a currently valid card in First Aid/ while in the facility at all times when residents were there.

Findings include:

A review of the personnel record during the survey for two (2) day time caregiver staff (A; D) and the AM LPN (E) found that the First Aid and certification had expired for Staff A, while no First Aid or documentation could be found for Staff D. In addition, although Staff E (LPN) had her license available for

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review, this employee's card could not be located. Interview with the administrative designee revealed that this certification was unavailable for review.

Class III

0090-Training - 58A-5.0191(11) FAC

Based on record review and interview, one of four staff sampled (A) had not received the required training in the facility's policies and procedures regarding

Findings include:

A review of personnel files during the survey indicated that Staff A, hired , had no documented evidence verifying that she had received any official training in the facility's policies/procedures pertaining to . Interview with the administrative designee at approximately 1:00pm on confirmed that this training certificate had not been provided.

Class III