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	AL11965786	10/08/2013
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0026 - 58a-5.0182(2) Fac - Resident Care - Social & Leisure Activities 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 - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0076 - 58a-5.0186 Fac - S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0167 - 58a-5.025(1) Fac - Resident Contracts S-S= B

Specific Tag Findings:

0000-Initial Comments
An unannounced re-licensure survey with Limited Nursing Services was conducted on Four Seasons Assisted Living Facility had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on record review and interview the facility failed to ensure the AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010 included the required information for 3 of 8 sampled residents (#1, #2 & #4).

Findings:

1. Review of record for resident #1 revealed the AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities updated on that stated diagnoses of and hip The 1823 did not state what type of assistance the resident needed with medications.

In an interview with the administrator on at approximately 3:45 PM who stated she was not aware the 1823 was not completed as required.

2. Review of the medical records for resident #2 indicated the resident was admitted to the facility on with diagnoses of Parkinson's of the and The latest resident assessment (AHCA form 1823) dated

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by the attending physician indicated the resident: on physical or sensory limitations- needs a walker for ambulation; cognition-stable, needs to be reminded of medications and monitor sugars; nursing treatmen service requirements- monitor glucose, administer medications; special precautions- precaution. On the question: Does the individual need help with taking his or her medications? The physician did not respond to the question. It was left blank. There was no response if the resident requires assistance or she can do it herself with supervision. The yes and no questions were not addressed. The form 1823 indicated; if a "yes" was responded it prompted to describe. The physician did not describe the kind of assistance the resident requires for medication administration.

In an interview with the staff #A on at 12:15 p.m. he stated that the resident has some periods of and forgetfulness and most of the time he has to give her the injection. In an interview with the owner/administrator on at 3:30 p.m. she validated that the attending physician who conducted the physical examination did not complete the health assessment completely as required.

3. Review of record for resident #4 revealed the AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities dated that stated diagnoses of The 1823 did not state what type of assistance the resident needed with medications.

In an interview with the administrator on at approximately 3:45 PM who stated she was not aware the 1823 was not completed as required.

Class III

0026-Resident Care - Social & Leisure Activities 58A-5.0182(2) FAC
Based on observation, interview and record review the facility failed to provide an ongoing activity or a scheduled activity program for 3 of 8 residents.

Findings:

Observations during initial tour of the facility on at 9:30 a.m. found 4 residents in the living front of the television. There were 3 residents inside their and there was 1 resident outside the front porch waiting for a ride for a physician's appointment and another resident walking around the facility.

In an interview with resident #5 on at 11:30 a.m. she stated that the facility does not provide any activities. She indicated that the facility should have a staff that would organize

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group activities. She further stated that they sit around all day or stay in their .

In an interview with resident #2 on . at 10:15 a.m. she stated there are no set activities, "none" you can do whatever you want to do. In an interview conducted with resident #4, on . at 11:00 a.m. she stated that there is no set activities but she goes for walks around the facility grounds and sometimes if they do offer any activity she would participate but most of the time they can do whatever they chose to do during the day.

An interview was conducted with staff #A on . at 12:15 p.m. he stated sometimes they would have karaoke night or movies. But there was no set activity program to be followed; he further indicated the staff is busy to include activities in their duties. An interview was conducted with a visiting family member on . at 11:15 a.m. she stated they have activities such as birthday parties or bingo but was unable to verify when.

Review of the facility activity calendar for the month of , 2013 indicated the following activities: Monday- sing along time; Tuesday - bend and stretch; Wednesday- bingo; Thursday- nail and polish party; Friday- movie and popcorn; Saturday- sittercise, music/dancing and Sunday- gospel program. This calendar is the same every week. There is no variation of the activities. On the day of survey, . the scheduled activity was for "bend and exercise" this was not observed done throughout the day (9:00 a.m. to 5:00 p.m.). There is 3 staff; a cook/housekeeping and a direct caregiver for day shift (7 a.m. -7 p.m.) who assists the residents with their medications and also provides assistance to residents who require supervision and assistance with activities of daily living (ADL's). The cook helps out in the housekeeping duties. There is 1 staff during the night shift (7 p.m.-7 a.m.). There is no staff assigned to organize and conduct individual or group activities.

In an interview with the administrator on . at 4:00 p.m. she validated that they did not provide the scheduled activity that day. She also admitted that the activity schedule is repetitive with no variation to meet individual needs and interests.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and interview the facility did not ensure physical . were limited to the use of half bed rails, used only with a biannual, written order from the resident's physician and with the consent of the resident or the resident's representative for 2 of 8 sampled residents (#1 & #8).

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Findings:

1. Tour of the facility on at approximately 9:15 AM revealed resident #1 was observed in a chair with a lap tray in place. She was also observed on in the chair with the lap tray in place at 10 AM, 10:50 AM and 11:45 AM. The resident was restrained in the chair until approximately 12:40 PM on when the physical arrived, removed the lap tray and ambulated the resident in the facility.

Interview with the administrator on at approximately 11:50 AM who stated the resident was not on hospice.

Review of the record for resident #1 revealed an Assisted Living Facility Health Assessment Form (1823) updated on that stated diagnoses of and hip and stated she was alert and The resident needed assistance with ambulation, bathing, dressing, transferring, toileting and was independent in eating and stated she was alert and

Observation during tour of the facility on at approximately 9:30 AM revealed resident #1 had 1/2 side rails on her bed. The resident was unable to raise and lower the rails due to her physical condition and status. The resident was and was not interviewable.

There was no documentation to review to indicate there was an order for the use of the 1/2 bed rails or the chair or a consent for the use of the bed rails.

In an interview with administrator on at approximately 2:30 PM who stated the resident her hip in or 2013. We put her in the chair as she tried to get up and walk. We also put her in a wheelchair. She did not have an order to use chair with lap tray, an order for 1/2 side rails or a consent for the use of the rails.

2. Tour of the facility on at approximately 9:15 AM revealed resident #8 had full side rails on her bed. Interview with the administrator on at approximately 9:45 AM who stated the resident was on hospice.

Focused record review revealed an 1823 dated with diagnoses of and needed assistance with medications. The resident was unable to raise or lower the side rails due to her physical condition and status.

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There was no documentation to review that indicated there was a physician's order or a consent signed by the resident's representative for the use of the rails.

In an interview with administrator on [redacted] at approximately 2:30 PM who stated the resident did not have an order or a consent signed for the use of the rails.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations and interviews the facility failed to ensure that when staff provided assistance with self-administration of medications, the staff followed the appropriate procedure to take the medication, in its dispensed, properly labeled container to the resident , in the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, close the container, return the medication to storage and chart the medications for 4 of 8 sampled residents (#1, #4, #7 & #8).

Findings:

1. Observation of the medication pass on [redacted] at 10:45 AM for resident #4 revealed the unlicensed staff obtained [redacted] 325 milligrams (mg) 1-2 tablets every 4-6 hours as needed for break through pain from the locked medication cart. She obtained the medication from locked storage, poured 2 tablets into the souffle cup, charted the medication and gave it to resident. She did not take medication in the labeled package to resident, read label and chart after medication was given.

Observation of the medication pass on [redacted] at 12:10 PM for resident #4 revealed the unlicensed staff obtained [redacted] (for pain) 4 mg by mouth take one 1 to 4 times a day as needed, and Gas Relief 180 mg one [redacted] as needed for gas from the lock medication cart. She poured the medications in a souffle cup, returned the medications to locked storage, charted medications, gave to resident and stated to take them one by one. She did not take medication in the labeled package to resident, read the label and chart after the medication was given.

2. Observation of the medication pass on [redacted] at 12:15 PM for resident #7 revealed the unlicensed staff obtained [redacted] 50 mg every 6 hours as needed for pain and [redacted] 0.5 mg every 4 hours as needed for [redacted] from locked storage. She put the medications in a cup, charted the medications, took the medications to the resident and did not read the label to resident. She did not take medication in the labeled package to resident, read label and

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chart after the medication was given.

3. Observation of the medication pass on at 12:20 PM for resident #1 revealed the unlicensed staff obtained 1 mg take 2 tablets by mouth at lunch at 12 pm for from locked storage, put the medications in a souffle cup, charted the medication and poured water in a cup. The resident was feeding herself lunch, the staff attempted to give one pill one at a time to resident, she did not read label to resident and the resident was unable to put pill in her mouth. The staff stated she would return to give her pills to her after lunch. The souffle cup was returned to the lock storage and put in with her medications.

On at 1:15 PM the staff obtained the from locked storage, crushed the pills and put in pudding, gave to resident, did not read label to resident, put the spoon in resident's hand with pudding and the resident fed herself the pudding. She did not take the medication in the labeled package to resident and read the label.

4. Observation of the medication pass on at 12:35 PM for resident #8 revealed the unlicensed staff obtained 1 mg take one at 12 PM for from locked storage, crushed the medication, put it in pudding, tried to arouse the resident, told the resident to open her mouth, put the pudding on the spoon, fed to the resident, the resident asleep and did not eat all of the pudding. The unlicensed staff wrapped pudding in foil, labeled with resident's name, put in the unlocked refrigerator, did not chart refusal and stated she would give resident medication later. At 3:10 PM on , the resident woke up and the staff took the pudding out of the refrigerator and fed the pudding with medication in it to the resident. The staff did not take the medication, in its dispensed, properly labeled container to the resident, in the presence of the resident, read the label, open the container, remove a prescribed amount of medication from the container, close the container, return the medication to storage and chart the medication.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on interview and record review the facility failed to ensure medications were administered by a licensed staff for 2 of 8 residents (#2 and #8).

Findings:

1. Review of the medical records for resident #2 indicated the resident was admitted to the

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facility on [redacted] with diagnoses of Parkinson's [redacted] of the [redacted] and [redacted]. Review of the latest resident assessment (AHCA form 1823) dated [redacted] by the attending physician indicated the resident: on physical or sensory limitations- needs a walker for ambulation; cognition- stable, needs to be reminded of medications and monitor [redacted] sugars; nursing treatmen [redacted] service requirements- monitor [redacted] glucose, administer medications; special precautions- [redacted] precaution. On the question: Does the individual need help with taking his or her medications? The physician did not respond to the question. It was left blank. There was no response if the resident requires assistance or she can do it herself with supervision. The yes and no question were not addressed. If a "yes" was responded it indicated to describe. The physician did not describe the kind of assistance the resident requires for medication administration.

In an interview with the staff #A on [redacted] at 12:15 p.m. he stated that the resident has some periods of [redacted] and forgetfulness and most of the time he has to give her the [redacted] injection. He admitted that he has no medical background and no formal training and is not licensed to administer the [redacted] injection. Review of staff training indicated the staff has medication training to supervise residents on [redacted]. The medication training does not include administration of injectables. This is conducted by a licensed staff as required. Review of the medication observation record (MOR) indicated the staff has been signing their initials on the Lantus [redacted] 100 units per milliliter (ml.) vial inject 30 units [redacted] at bedtime. There was also an order for [redacted] R 100 units per ml. vial to inject per sliding scale before breakfast and dinner. On 4 occasions (month of [redacted] this was administered to the resident to cover the results of the [redacted] glucose monitoring (conducting [redacted] glucose testing). The staff admitted that [redacted] glucose monitoring was also conducted.

In an interview with the owner/administrator on [redacted] at 3:30 p.m. she validated that the attending physician who conducted the physical examination did not complete the health assessment completely as required. She further indicated that the family member comes frequently and assist the resident with the [redacted] injection and [redacted] glucose testing.

2. Review of physician orders for resident #8 dated [redacted] stated [redacted] (for [redacted] 1 milligram (mg) by mouth 8 AM, at 12 PM and 1 1/2 at bedtime. Observation of the medication pass for resident #8 on [redacted] at 12:35 PM revealed the unlicensed staff obtained the [redacted] from locked storage, crushed the medication, put the medication in pudding, tried to arouse the resident, told the resident to open her mouth, put the pudding on spoon, attempted to feed the medication in the pudding to the resident, the resident [redacted] asleep and did not eat all of the pudding.

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The unlicensed staff administered medications to resident #8, which required a nurse for administration of medications.

Record review revealed an 1823 dated with diagnoses of and needed assistance with medications.

Interview with the administrator on at approximately 4 PM who was not aware the unlicensed staff was administering medications.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation, interview and record review the facility failed to ensure medications requiring refrigeration was secured in a locked container; and expired and discontinued medications were disposed as required for 2 of 8 sampled residents (#2 and #8).

Findings:

1. On at 1:30 p.m. an observation was conducted in the refrigerator located in the facility kitchen which was open for anybody to come in and out. This refrigerator was used for the food of the residents and was not locked. In one of the compartments, refrigerated medications were stored. The following medications were found in that compartment:

1. Lantus 100 milligrams per milliters (mg/ml) x 4 bottles for labeled for resident #2.

2. Regular 100 mg/ ml x 8 bottles for labeled for resident #2.

3. (for bones) 200 International Units (IU) spray 1 bottle labeled for resident #8; no record that resident was on it but labeled "opened on

4. (for pain) 650 mg. insert 1 per as needed every 6 hours. Resident on that medication has expired on

5. Comfort pack for resident #5 from Hospice per label it indicated the small box contained controlled substance.

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6. Comfort pack for resident #8 from hospice with controlled substance

Per interview with the administrator on at 2:00 p.m. she stated they do not have a policy and procedure for disposal of medications when a resident expires/discharged or the medication is discontinued. She stated she usually returns the medications to the family or to the pharmacy. The owner admitted that she failed to obtain a lock for the refrigerated medications which is accessible to anybody who comes to the kitchen and opens the refrigerator, e.g. staff, residents and visitors.

2. Observation of the medication pass for resident #8 on at approximately 12:35 PM revealed the unlicensed staff obtained (for from locked storage, crushed medication, put in pudding, tried to arouse the resident, told the resident to open mouth, put pudding with medication on the spoon, fed to the resident, the resident asleep and did not eat all of the pudding. The unlicensed staff wrapped the pudding with the medication in it with foil covering it, labeled with the resident's name, put in the unlocked refrigerator and stated she would give the medication to the resident later. At 3:10 PM the resident woke up and the staff took the pudding out of the unlocked refrigerator and fed the pudding with medication to the resident.

The medication was in pudding stored in the unlocked refrigerator.

Interview with the administrator on at approximately 3:45 PM, who was not aware the medication was in pudding in the unlocked refrigerator.

Class III

007(58A-5.0186 FAC
Based on record review and interview the facility failed to provide a copy of Form SCHS-4-2006, " Health Care Advance Directives - The Patient ' s Right to Decide, " 2006, or with a copy of some other substantially similar document, which incorporated information regarding advance directives included in Chapter 765, F.S. to 2 of 8 sampled residents (#1 & 2).

Findings:

Resident record review for residents #1 and #2 revealed the facility did not provide a copy of Form SCHS-4-2006, " Health Care Advance Directives - The Patient's Right to Decide,"

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2006, or with a copy of some other substantially similar document, which incorporated information regarding advance directives included in Chapter 765, F.S. to residents.

Interview with the administrator on [redacted] at approximately 4 PM who stated the residents did not get the advance directive packet.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on observation, record review and interview the facility failed to ensure all staff were assigned duties consistent with his/her level of education for 2 of 8 sampled residents (# 2 & 8) and did not administer their medications.

Findings:

1. Review of the medical records for resident #2 indicated the resident was admitted to the facility on [redacted] with diagnoses of Parkinson's [redacted] of the [redacted] and [redacted] Review of the latest resident assessment (AHCA form 1823) dated [redacted] by the attending physician indicated the resident: on physical or sensory limitations- needs a walker for ambulation; cognition-stable, needs to be reminded of medications and monitor [redacted] sugars; nursing treatmen[redacted] service requirements- monitor [redacted] glucose, administer medications; special precautions- [redacted] precaution. On the question: Does the individual need help with taking his or her medications? The physician did not respond to the question. It was left blank. There was no response if the resident requires assistance or she can do it herself with supervision. The yes and no question were not addressed. If a "yes" was responded it indicated to describe. The physician did not describe the kind of assistance the resident requires for medication administration.

In an interview with the staff A on [redacted] at 12:15 p.m. he stated that the resident has some periods of [redacted] and forgetfulness and most of the time he has to give her the [redacted] injection. He admitted that he has no medical background and no formal training and is not licensed to administer the [redacted] injection. Review of staff training indicated the staff has medication training on [redacted] The medication training does not include administration of injectables. This is conducted by a licensed staff as required. Review of the medication observation record (MOR) indicated the staff has been signing their initials on the Lantus [redacted] 100 units per milliliter (ml.) vial inject 30 units [redacted] at bedtime. There was also an order for [redacted] R 100 units per ml. vial to inject per sliding scale before breakfast and dinner. On 4 occasions (month of [redacted] this was administered to the resident to cover

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the results of the glucose monitoring (conducting glucose testing). The staff admitted that glucose monitoring was also conducted.

In an interview with the owner/administrator on at 3:30 p.m. she validated that the staff were conducting procedures out of their scope of their qualifications and training.

2. Review of physician orders for resident #8 dated stated (for 1 milligram (mg) by mouth 8 AM, at 12 PM and 1 1/2 at bedtime. Observation of the medication pass for resident #8 on at 12:35 PM revealed the unlicensed staff obtained medication from locked storage, crushed the medication, put the medication in pudding, tried to arouse the resident, told the resident to open her mouth, put the pudding on spoon, attempted to feed the medication in the pudding to the resident, the resident asleep, and did not eat all of the pudding.

The unlicensed staff administered medications to resident #8, which required a licensed nurse for administration of the medication.

Record review revealed an 1823 dated with diagnoses of and needed assistance with medications.

Interview with the administrator on at approximately 4 PM who was not aware the unlicensed staff was administering medications.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on record review and interview the facility failed to ensure they had the required amount of food and water in the 3 day emergency supply and menus were reviewed annually.

Findings:

Review of the emergency food supply on at approximately 2 PM revealed there was no milk available. Based on a census of 9 residents the amount of milk to be available for 9 residents x 0.5 quarts x 3 days was = 13.5 quarts.

There were 12 gallons of water available. Based on a census of 9 residents, the amount of

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water needed was 9 residents x 3 days - 27 gallons. The facility needed 15 more gallons of water.

Review of the menu revealed it expired on . . . . . There was no documentation to review to indicate the menu had been signed on . . . . . .

Interview with the administrator on . . . . . at approximately 4:15 PM who stated she needed to purchase more milk and water and confirmed the menu had expired.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on observation, record review and interview the facility failed to ensure health care provider's orders were obtained to crush medications for 2 of 8 sampled residents (#1 & 8).

Findings:

1. Observation of the medication pass on . . . . . at 12:20 PM for resident #1 revealed the unlicensed staff obtained . . 1 milligram (mg) take 2 tablets by mouth at lunch at 12 PM for . . from locked storage, put the medications in a souffle cup, charted the medication and poured water in a cup. The resident was feeding herself lunch. The staff attempted to give one pill one at a time to the resident and the resident was unable to put pill in her mouth. The staff stated she would return to give her pills to her after lunch. The souffle cup was returned to lock storage and put in with her medications. On . . . . . at 1:15 PM the staff obtained the . . from locked storage, crushed the pills and put in pudding, gave to resident, put the spoon in resident's hand with the pudding and the resident fed herself the pudding.

Review of the record for resident #1 revealed an Assisted Living Facility Health Assessment Form (1823) updated on . . . . . that stated diagnoses of . . and hip . . . . . and stated she was alert and . . . . . There was no documentation that indicated what type of assistance the resident needed with medications.

Record review revealed there was no documentation to review that indicated there was a physician order to crush medications.

Interview with the administrator on at approximately 3:45 PM who stated she was not aware the medications were crushed for the resident and there was no crush order.

2. Observation of the medication pass for resident #8 on at 12:35 PM revealed the unlicensed staff obtained 1 milligram at 12 PM from locked storage, crushed the medication, put the medication in pudding, tried to arouse the resident, told the resident to open her mouth, put the pudding on spoon, attempted to feed the medication in the pudding to the resident, the resident asleep and did not eat all of the pudding.

Record review revealed an 1823 dated with diagnoses of and needed assistance with medications.

Record review revealed there was no documentation to review that indicated there was a physician order to crush medications.

Interview with the administrator on at approximately 3:45 PM who stated she was not aware the medications were crushed for the resident and there was no order to crush medications.

Class III

0167-Resident Contracts 58A-5.025(1) FAC
Based on record review and interview the facility failed to ensure the contract included the Limited Nursing Services (LNS) costs for 2 of 8 sampled residents.

Findings:

Review of contracts for resident #1 and #2 revealed and LNS costs were not included in the contract.

In an interview with the administrator on at approximately 4:15 PM who stated she was not aware the contract did not state the LNS costs.

Class

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Four Seasons Alf
5080 Wayside Drive
Sanford, FL 32771

Dear Administrator:

Re: Biennial w/LNS

This letter reports the findings of a state licensure survey that was conducted on , 2013 by representative(s) 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(s). Should you have any questions please call Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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