STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968314	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Wiley Retirement Home	**7024 Wiley Rd Jacksonville, FL 32210**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0007-Admissions - Criteria-11/26/2013
0008-Admissions - Health Assessment-11/26/2013
0054-Medication - Records-11/26/2013
0058-Pharmacy & Dietary; Uncorrected Deficiencies-11/26/2013
0081-Training - Staff In-Service-
0165-Risk Mgmt & Qa; Adverse Incident Report-
0167-Resident Contracts-

Revisit Repeat Tags:
0000-Initial Comments-
0025-Resident Care - Supervision-58a-5.0182(1) Fac
0030-Resident Care - Rights & Facility Procedures-58a-5.0182(6) Fac; 429.28 Fs
0055-Medication - Storage And Disposal-58a-5.0185(6) Fac
0056-Medication - Labeling And Orders-58a-5.0185(7) Fac
0077-Staffing Standards - Administrators-58a-5.019(1) Fac
0078-Staffing Standards - Staff-58a-5.019(2) Fac
Z815-Background Screening; Prohibited Offenses-408.809, 435.02(2), 435.06

Specific Tag Findings:

0000-Initial Comments
An unannounced second revisit to a complaint survey, CCR# 2013005735, was conducted at Wiley Retirement Home in Jacksonville, Florida on , 2013. Uncorrected deficiencies were identified as a result of the survey.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review and interview, the facility failed to contact the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate or case manager if the resident exhibited a significant change for two of 4 sampled residents. (Residents #1 and #7)

The findings include:

A review of the clinical record for Resident #1 revealed that he was admitted to the facility on , and he was discharged on to Orange Park Medical Center (OPMC). He did not return. A record review revealed discharge instructions dated from OPMC for head injury with wake up. A recommendation indicated that Resident #1 should "follow up with Internal Medicine tomorrow", . No documentation was available in Resident #1's clinical record to support a follow- up visit with the physician. A review of the discharge summary from OPMC dated revealed instructions for care following . A note recommending a follow- up with the physician if condition worsened was observed. Discharge instructions from OPMC dated stated, "Hip pain/ " and recommended follow- up with Resident #1's primary care physician in two days, . No documentation to support a follow- up with Resident #1's physician was obtained.

A review of clinical record documentation for Resident #1 revealed the following:

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13, 2013 at 3:30 PM: "Laying on the floor in front of his door." and documented compress and a dressing. No evidence of Family and MD notification.

, 2013 at 8:46 PM: "Heard a loud slam inside , saw resident on the floor, and notified the administrator and hospice. No evidence of family or MD notification.

, 2013 at 6:55 PM: 'Resident was found on the floor on his left side of his face by staff during last rounds. He started complaining of left shoulder pain. Administrator was informed, and she called the family and ambulance.' No evidence of MD notification.

,2013 at 10:10 PM: He was found on the floor of his , trying to get up. The resolution was documented as " Checked for and found nothing except scrape of his skin in the forehead and elbow. Cleaned the and apply 4x4, make him comfortable in bed." No evidence of MD or family notification. (photos obtained)

An interview with the administrator at 4:51 PM on revealed " He didn ' t ' do right. He would make many attempts to walk himself; he didn ' t ' t want to let go of his independence. " The administrator stated that Resident #1 " all the time". She stated, "They just couldn ' t keep him from falling. He went to the hospice center from the hospital, and then he . He had been declining for a long time."

A review of the clinical record for Resident #7 revealed that he sustained a on at 8:41 PM. The clinical record documentation read that Resident #7 was calling for help, and that he was discovered lying on the floor in front of the door to his . He declined to go to the E.R. 'Has wounds on his knees (left) and first aid applied.' Informed administrator who instructed the staff to observe for "unusual behavior". There was no documentation indicating that the physician or the family were notified.

A review of the daily communication log for revealed no mention of a . Documentation in the log dated at 11:00 AM indicated that Resident #7 was complaining of back pain. "Informed administrator; 2 given". At 11:10 AM on , documentation in the same log indicated that Resident #7's daughter and husband came at 11:30 AM, and decided to send Resident #7 to the Mayo Clinic ER.

This was previously cited on .

Class III

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

Based on interview and record review, the facility failed to establish and implement a grievance procedure to facilitate the residents' exercise of this right for 2 (Residents #4 and #5) of 20 sampled residents.

An interview was conducted on at 8:55 AM with Resident #4. He said that someone had taken money, cigarettes and candy from his . He said that he caught the person who did it. When asked whether he had reported this to anyone, he replied that he had reported it. He added that both of his hearing were taken "about a month ago". Resident #4 said that he believed the same person took the hearing who took his money, cigarettes and candy. He said that as far as he knew, nothing had been done about it.

An interview with Resident #4's son was conducted on at 12:20 PM. When asked whether he was aware of Resident #4's missing hearing he replied that he was. Resident #4's son said, "Yes, he came in this place with them, but they were stolen. We reported this about a month ago. The staff knows about it from what I was told, but he never got them back."

An interview with the administrator on at 3:35 PM revealed that "A resident goes into Resident #5's for cigarettes. He is violating Resident #5's rights. Resident #5 told me a few days ago to keep him

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out of his room." The administrator said that Resident #5 placed a note on his door telling the other resident to stay out of his room. The administrator explained that the accused resident mentioned that he saw that note. When asked whether the administrator had written a grievance, she stated, "No, I did not; I thought grievances were for serious complaints."
An interview with Resident #5 on at 9:50 AM revealed the following: Resident #5 stated, " I keep my toiletries in my bag." (Shave kit on his walker seat) Resident #5 said that he had some things on the shelves, and "people come in and help themselves". He said that he did not know who did this. He said that he was not able to recall how recently this happened. He said, "Everybody knows the people here just help themselves." He said that he couldn't lock any belongings up, because there were no cabinets to lock, and there was no lock on the door to his .
A review of the policy and procedure for grievances revealed that the administrator should be notified immediately of any grievance, and that a written report including the party filing the complaint, the date of the occurrence, the nature of the complaint, the resident's name if applicable and the relationship of the complainant to the resident should be included. A timeline for resolution of a given grievance was established in the policy and procedure.

A review of the grievance policy and procedure with the administrator at approximately 6:00 PM confirmed that the facility staff were not following their own guideline for grievances. The administrator said, "I understand now. Any complaint should really go on a grievance form, so that we can show how we followed up on the problem."

This was previously cited on .

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observation and interview, the facility failed to store prescribed medication in a centrally locked area for 1 (Resident # 6) of 20 sampled residents. The facility also failed to discard opened and undated or unlabeled for 2 of 2 sampled residents receiving . (Residents #2 and #3)

The findings include;

On at 9:00 AM an observation was made of Resident # 6 carrying a box of a prescription medication in her hand. A spray bottle of medication was observed. Instructions on the pharmacy label indicated that the resident should use two sprays in each nostril once a day. Resident #6 said that she used the medication once daily. Then she said,"The nurse gave it to me, I will take it back to her after my shower." She added that she had used it the previous night, and that one of caregivers had given it to her.

On at 9:30 AM an interview with Employee B revealed that Resident #6 required assistance with self -administration of medication. Employee B said that the resident had a doctor's appointment yesterday.

An interview on at 9:35 AM with the administrator revealed that Resident #6 said she had an order for nose spray. The administrator said that Resident #6 didn ' t ' T have a prescription yet that she was aware of. The administrator said that she called the physician's office on after Resident #6 returned from the appointment, because Resident #6 said that she was given a prescription for . The administrator said that she asked the secretary at the doctor ' S office for a hard copy of the order or to fax it to the pharmacy. The

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administrator said that at some point in time the medication must have been delivered. The administrator said that the resident should not have received this medication herself. It should have been locked up in the medication cart. The administrator pulled the MOR and said, "It is not written on the MOR." She then wrote the medication with the instructions for administration on the MOR just as it was written on the bottle pharmacy label.

An observation of the medication refrigerator contents on at approximately 12:10 PM revealed that there was a padlock on the refrigerator door with a combination lock. Inside of the refrigerator was observed a plastic bin with a lid marked for Resident #2. Inside of the bin was an open vial of Lantus labeled for Resident #2. There was no " open " date on the vial. The directions for use were identical to the other vial of Lantus that Mr. Glover injected at 11:51 AM on . (photo) Another opened vial of 100 units/ml was discovered in the refrigerator. The label read, inject SQ depending on sliding scale. There was no " open " date on the vial. (photo) During observation of the medication refrigerator two unlabeled vials of were noted. One bottle of was opened with no " open " date or label indicating which resident it belonged to on the vial. The other vial of R was unopened and without a label indicating which resident it belonged to. There were no containers of any kind available for these unmarked vials. (photos). Also discovered were two boxes containing vials of R for Resident #3. Inside each box was an open vial with no " open date " marked on it. (photos)

An interview with the administrator at approximately 12:30 PM revealed that she thought the pharmacist had cleaned out the refrigerator when he did his medication audit. She said, "I know that those should have been thrown out. I don't know why they haven't been."

This was previously cited on .

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observation, record review and staff interview, the facility failed to refill prescribed medication for 5 (Residents #2, #5, #10, #11, and #12) of 20 sampled residents.

The findings include;

On at 12:30 PM a medication observation was conducted with Employee A. She opened her Medication Observation Record (MOR) to give Resident #5 his medication. After observing the MOR, Employee A stated, " Oh no, I cannot give it, it is not available. This is the fourth day it is signed as unavailable. " She explained that the facility kept calling the pharmacy to try to obtained the medication. The medication 80 milligrams (mg) 1 tablet by mouth three times a day was written on the MOR. The medication had been signed as unavailable from through .

Employee A further stated that Resident #2 hadn't had any of his medication "in a while", because "we cannot get a hold of the doctor to get a hard copy of the prescription." Observation of Resident #2's MOR revealed that he did not receive his 10 mg tablet, and it was signed as unavailable from // through .

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An interview was conducted on at 12:34 PM with the Administrator. She said that she had called the doctor, but he was out of town so she called the Physician Assistant (P.A.) to re-order the prescription. The P.A. said he would not re-order the medication since the doctor was out of town. The Administrator further stated, " There was nothing we could do. "

A record review of Resident #5's clinical record revealed that the health assessment medications page listed 80 mg 1 tablet by mouth three times a day as ordered by Resident #5's physician.

A record review of Resident #2's clinical record revealed that the Health Assessment medications page listed 10 mg by mouth daily as ordered by Resident #2's physician.

Further review of the MOR revealed that Resident #10 was prescribed 500 mg, take one pill twice daily. The MOR was signed for multiple days as unavailable.(1 , and) Resident #11 was prescribed 50 mg three times daily. The MOR was signed as unavailable from through . Resident #12 was prescribed Cardevilol 6.25 mg tablets which were signed as unavailable from / through .

This was previously cited on .

Class II

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on observation, record review and interview, the administrator failed to operate the facility in an effective manner to ensure that staff had appropriate background screenings, and that residents received adequate care in the areas of supervision, medication management and resident rights potentially affecting all (20) residents in the building.

The findings include:

The administrator failed to ensure that Employee E had a level II background screening. (See Z815)

The administrator failed to ensure that residents' medications were labeled appropriately, and that had dates labeled on the vials indicating when the vials were opened. (See A0056)

The administrator failed to ensure that residents' responsible parties and residents' physicians were notified of significant changes in status. (See A0025)

This was previously cited on .

Class II

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on record review and interview, the facility failed to ensure that newly hired staff submitted a statement from a health care provider within 30 days of employment, based on an examination conducted within the last six months, that the person did not have any signs or symptoms of a communicable including

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for 1 of 4 sampled employees. (Employee D)

The findings include:

A review of the employee personnel file for Employee D on revealed a hire date of and no documentation of freedom from communicable or a ( ) test with test results available for review.

An interview with Employee D on at approximately 6:54 PM confirmed that this documentation had not yet been obtained. "I know I need to have it done. I just haven't done it yet."

A review of the employee personnel file for Employee F on revealed a hire date of and no documentation of freedom from communicable or a ( ) test with test results available for review.

An interview with the administrator (Employee D) on at approximately 6:54 PM confirmed that Employee F had no documentation of freedom from communicable including in her personnel file. The administrator stated that Employee F had an appointment with her physician on . The administrator also admitted that Employee F was working with and having direct contact with residents.

This was previously cited on

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06
Based on record review and interview, the facility failed to obtain a level II background screening for 1 of 9 sampled employees. (Employee E)

The findings include:

A review of the personnel file for Employee E on revealed no level II background screening available for review.

An interview with the administrator on at approximately 6:30 PM confirmed that there was no level II background screening available for Employee E. The administrator stated that she would obtain the appropriate documentation and send it to the AHCA Area 04 office, however, this documentation never arrived.

This was previously cited on

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Wiley Retirement Home
7024 Wiley Road
Jacksonville, FL 32210

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Complaint Survey CCR #2013005735, conducted on 26, 2013 by representatives of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies that were identified on the day of the visit.

All deficiencies shall be corrected no later than , 2014.

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 this office at (904) 798-4201.

Sincerely,

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

JV/MB/KW/sm
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 798-4201; Fax (904) 359-6054