STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966400	05/20/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Phoenix Senior Living Ii, Inc.	5882 Nw 73rd Court Parkland, FL 33067	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D

Specific Tag Findings:

0000-Initial Comments

A Standard Biennial Re-licensure Survey was conducted on . . . . . at Phoenix Senior Living II, Inc. At the time of the survey, deficiencies were identified.

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

Based on observation, record review, and interview, the assisted living facility failed to provide assistance with self-administration of medication per the guidelines as noted in 429.256, F.S for 3 out of 6 (Resident #1, #3, #6) current residents. Assistance with self-administration guidelines require: verbally prompting a resident to take medications as prescribed and trained staff observing the resident take the medication. Assistance with self-administrator guidelines do not include: administration and regulation of . .

Findings include:

1) Observations on . . . . . at approximately 8:04 AM found a for resident #1. Observations found resident #1 lying in her respective bed. Observations found resident #1's bed was in a seated-like position. Observations found resident #1 was using an . . concentrator at the time (cannula under her nose).

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Observations on at approximately 8:20 AM found staff B in resident #1's
Observations found staff B walked over to resident #1, removed the cannula from under her nose, and turned off the concentrator.

In an interview with staff B on at approximately 8:20 AM, she stated she was going to shower resident #1 so she could bring her to the dining breakfast. She stated resident #1 is hard of seeing and hearing. She stated resident #1 is not capable of turning on and off the concentrator. She stated resident #1 usually takes it off but she took it off for her because she was sleeping. She stated she always has to hand it to her in order for her to be able to put it on. She stated she is not a licensed nurse.

In an interview with staff A on at approximately 8:24 AM, she stated staff B is not a licensed nurse and confirmed that staff B was her daughter. She also stated that she too is not a licensed nurse.

In an interview with staff A on at approximately 10:10 AM, she stated resident #1 uses She stated they have to help her because she cannot do it on her own. She stated she wears it during bedtime. She stated she puts it on for her. She stated they take it off of her in the morning when they shower her. She stated resident #1 is not capable of turning on and off the machine. She stated resident #1 is

Record review of resident #1's file revealed a health assessment dated Record review of the health assessment revealed resident #1 needed both assistance with self-administration of medication and medication administration.

Record review of the facility's license revealed the facility did not have a Limited Nursing Services {LNS} component.

2) Observations on at approximately 8:32 AM found staff A transferred Resident # 6's medication into a small cup in the kitchen. Observations found she brought the cup over to the dining table with a cup of water and placed it in front of Resident # 6. Staff A was observed putting Resident # 6's medication into Resident # 6's mouth and then holding the cup of water up to Resident # 6's lips.

Observations on at approximately 9:00 AM found Resident # 6 eating cereal for breakfast with a spoon. Resident # 6 was able to use a spoon to put cereal in her mouth without any assistance.

Record review of Resident # 6's medications and Medication Observation Record revealed Staff A had given Resident # 6 the following medication: 10 mg 1 tablet, 0.5 1 tablet,

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10 mg 1 tablet, and Methnamine md 1 tablet.

In an interview with Resident # 6 on at approximately 10:32 AM, she stated when it's time to get my medication they usually bring it to me in a small cup along with a cup of water and they tell me to take them. She stated I take them and sometimes they help me take them.

During an interview with Staff A on at approximately 8:40 AM, she stated she has to assist Resident # 6 everyday by putting her medication into her mouth and then holding the cup of water to her lips because Resident # 6 is unable to do it on her own.

3) Observations on at approximately 8:56 AM found staff A transferred Resident # 3's medication into a small cup in the kitchen. She placed two pills into a small cup and brought the cup over to the dining table with a cup of water and placed it in front of Resident # 3. Observations found Staff A turned her back and walked away from the resident prior to resident #3 taking her medications. Observations found Staff A did not observe Resident # 3 taking her medications.

4) In an interview with the administrator on at approximately 1:15 PM, she acknowledged the findings and stated she knew that was coming except for the issue.

Class III

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

Based on observation, record review, and interview the assisted living facility failed to ensure all prescription medications and over the counter (OTC) products were secured at all times.

Findings Include:

1) Observations during a tour of the facility on at approximately 8:13 AM found 500 mcg spray on the kitchen counter in the facility. Observations found the kitchen counter was accessible to all residents.

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In an interview with staff A on at approximately 8:14 AM, she stated the on the counter was not a resident medication. She stated it belonged to one of the staff.

Observations on at approximately 1:40 PM found the 500 mcg spray was still on the kitchen counter in the facility.

In an interview with the administrator on at approximately 1:15 PM, she stated maybe one of her "girls" uses the on the counter. She stated she will tell "the girls" to put their stuff in their bags.

2) Observations on at approximately 10:07 AM found the refrigerator in the kitchen area with a box that contained prescription medication(s). Observations found the box had a lock on it but was not locked or properly secured. Observations found the refrigerator was not locked and the kitchen was accessible to all residents.

In an interview with staff A on at approximately 10:08 AM, she stated she does not have the key to the medication box in the refrigerator. She stated the home health nurse comes in and uses it.

In an interview with the administrator on at approximately 1:15 PM, after the administrator was showed the medication box located in the refrigerator was unsecured, she stated the home health nurse has the key to the box in the refrigerator. She stated she must have forgot to lock it. She stated she is the only one that touches the box.

3) Observations on from approximately 8:30 AM to approximately 9:30 AM found all six current residents were provided with assistance with self-administration of medication by unlicensed staff.

Record review of both resident #1 and resident #2's health assessment revealed, at minimum, both resident #1 and resident #2 required assistance with self-administration of medication. Record review of resident #1's health assessment revealed resident #1 had a diagnosis of and was "forgetful" and had "occasional at night". Record review of resident #2's health assessment revealed he was "very forgetful" and to place and time".

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0077-Staffing Standards - Administrators 58A-5.019(1) FAC

Based on record review and interview the assisted living facility failed to have an assistant administrator (manager) that completed the CORE training requirements.

Findings Include:

1) Website search of floridahealthfinders.gov revealed the administrator is currently supervising, and is the administrator of, a total of two assisted living facility.

Record review of staff A, staff B, and staff C's files found none of them had evidence that they completed the CORE training requirement. Record review found no other staff, besides the administrator, that worked at the facility.

2) In an interview with the administrator on at approximately 8:40 AM, she stated she has another assisted living facility located in Coral Springs, Florida. She stated she is also the administrator of that facility. She stated the manager is by rotation at this facility. She stated it is either staff A or staff B.

In an interview with the administrator on at approximately 1:15 PM, she stated that she is the only staff that completed the CORE training requirement. She stated she does not have a manager that has completed the CORE training requirement. She stated she was not aware that she needed a manager that has completed the CORE training requirement and inquired if this was a new rule. After the administrator was read the statutory language, she stated, she was not aware of this.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on personnel record review and interview, the assisted living facility failed to ensure that 1 out of 3 staff members (Employee C) facility employees had freedom from documented on an annual basis.

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The findings include:

1) During a record review of the personnel file for Employee C, a Home Health Aide (HHA), it was revealed that there was an employment start date of . . . . Record review on . . . . found freedom from . . was documented on . . . . . and the file did not contain documentation of an annual . . . test completed for 2014.

2) In an interview with the administrator on . . . . at approximately 1:10 PM, she confirmed that the only annual . . . verification found in Employee C's file was dated . . . . . She stated it looks like it expired in . and if it needs to get done then she will do it.

On . . . . . at 1:15 PM, the Administrator was interviewed and acknowledged the findings.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC

Based on record review and interview, the assisted living facility failed to maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period.

Findings Include:

1) Record review of the staff schedule revealed 3 shifts: Day shift 7 AM through 7 PM, Evening shift 7 PM through 12 AM and Night shift 12 AM through 7 AM. Staff schedule reveal Employee A and B works the day shift, the Administrator works the evening shift, and Employee C works the night shift.

Record review of the staff schedule for . . . revealed Employee B worked 7 PM through 12 AM and Employee C worked from 7 AM through 7 PM and then returned at 12 AM to work the night shift. Record review of the staff schedule revealed on . . that the Administrator was scheduled from 7 PM to 7 AM.

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2) During an interview with Employee B on at approximately 9:24 AM, she stated that she works the day shift from 7 AM through 7 PM. She stated that the Administrator works the evening shift from 7 PM until midnight. She stated that Employee C works the midnight shift from 12 AM through 7 AM.

In an interview with the Administrator on at approximately 12:45 PM, she stated on she worked from 8 AM through 6:00 PM. She stated Employee C is a floater and her shifts are rotated.

In an interview with the Administrator on at approximately 1:15 PM, she acknowledged that the posted staffing schedule was inaccurate and did not reflect the current work schedules.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC

Based on observation, record review, and interview the assisted living facility failed to ensure dietary standards were met. The facility failed to ensure the facility menu was followed at all times. The facility failed to ensure no more than 14 hours shall elapse between the end of an evening meal and the beginning of a morning meal.

Findings Include:

1) Observations on at approximately 9:01 AM found the residents that were at the dining at the time were served a bowl of cereal with milk.

Observations on at approximately 9:14 AM found the residents that were at the dining at the time were served a slice of toast (cut in half) with jam in the middle with banana and watermelon which were cut up for them.

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Observations on at approximately 9:21 AM found the residents were served coffee.

Observations on at approximately 9:23 AM found the residents were served juice. Observations found no other items were given to the residents for breakfast. Observations found the facility never served turkey bacon to the residents (as shown on menu) and failed to make an adequate substitution.

Record review of the facility menu revealed the following items were to be served for breakfast on 8 oz. coffee/tea, 1 banana, 6 oz. hot/ cereal, 1 slice toast, 2 tsp margarine, 2 tsp jam/jelly, 2 slice LS turkey bacon, and 8 oz. milk. Record review revealed the menu was signed by a registered dietician and expired on 11/

In an interview with staff A and the administrator on at approximately 9:51 AM, staff A stated that the are out of turkey bacon and they could not serve it. The administrator then stated it was between the bread and staff A responded and stated no it was jam. The administrator then stated to her to next time substitute so the residents get protein.

2) Observations on at approximately 9:01 AM found the residents started receiving their breakfast items.

Record review of a sign posted next to the dining revealed meal times were as follows: breakfast- 7:30 AM, lunch- 12:00 PM, and dinner 5:30 PM.

In an interview with staff A on at approximately 8:55 AM, she stated breakfast is never at 7:30 AM. She stated the morning shift get there at 7:00 AM and by the time they shower the residents and everything is done, they do not serve breakfast until 9:00 AM.

In an interview with staff B on at approximately 9:55 AM, she stated she arrived to the facility for a shift yesterday, at about ten minutes to 7:00 PM (6:50 PM). She stated at that time none of the residents were still eating dinner. She stated they all had finished by then.

In an interview with the administrator on at approximately 9:57 AM, she stated she was at the facility yesterday She stated she left around 6 PM right when the residents were finished with their dinner.

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3) In an interview with the administrator on at approximately 1:15 PM, she acknowledged the findings.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2014

Administrator
Phoenix Senior Living Ii, Inc.
5882 Nw 73rd Court
Parkland, FL 33067

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on . 2014 by representatives 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 (30) days** of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2014** 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/dso
Enclosure: State form 5000-3547
XG90

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