STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953542	06/27/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Cornerstone At Longwood (the)	480 East Church Avenue Longwood, FL 32750	
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 - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency 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 - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D

Specific Tag Findings:

0000-Initial Comments
Complaint investigation #2014003941 was conducted on and The Cornerstone at Longwood had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on resident record review and interview the facility failed to ensure 2 of 8 records (#2 & #7) reviewed contained a health assessment report that contained all the required information.

Findings:

Resident record review at approximately 1 PM for resident #2 revealed he was admitted to the facility on Continued reviewed revealed the health assessment was dated and did not address the resident's needs regarding self-administration of medications.

Resident record review at approximately 1 PM for resident #7 revealed she was admitted to the facility on Continued reviewed revealed the health assessment was dated and did not contain the examiner's medical license number and his/her practice address.

In an interview with the administrator on at approximately 3:30 PM, who confirmed the findings and stated the assessments were overlooked.

Class III

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observations, record review and interview the facility retained 1 of 6 sampled residents (#4) who needed total care with the activities of daily living and exceeded residency in the ALF.

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Findings:

During the facility tour on [redacted] at approximately 8:35AM staff B stated resident #4 was [redacted] of bowel and [redacted] needed assistance of 2 to ambulate and needed total care/assistance with activities of daily living. She added that resident #5 was also unable to do her activities of daily living and was unable to assist with bathing, [redacted], toileting and dressing. She was [redacted] of bowel and [redacted] as well.

Resident record review on [redacted] at approximately 11 AM revealed a health assessment report dated [redacted] for resident #4 that listed diagnoses of [redacted] compression [redacted] and [redacted]. She had [redacted] was forgetful and needed medication administration. Per assessment she required assistance with all the activities of daily living and supervision with eating.

In an interview with the administrator on [redacted] she stated the residents were able to assist sometimes and asked could the residents continued to live in the facility if they enrolled in hospice.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on record review and interview the facility failed to ensure: 1. there was a functioning complaint, follow-up and resolution mechanism in place to document and follow up on resident's complaints; 2. failed to ensure to preserve the residents rights to be treated with consideration and respect and with due recognition of personal dignity, individuality and the need for privacy and; 3. that the use of physical restrains was limited to half-bed rails only for 1 sampled resident (#1 & #3) and 4 Random sampled (RS #1, #2, #3 and #4).

Findings:

Observations during the facility's memory care unit on [redacted] at approximately 9 AM noted the bed on the left side of [redacted] # [redacted] that belonged to resident #1 had full bed rails in place.

Observations at approximately 9 AM noted that Random sampled (RS) #2 was on a recliner, leaned back. The recliner had an egg mattress and there a pillow under the legs. The resident was [redacted] unable to respond to questions and made involuntary arm and legs movements. His chair was in the right hallway by the common area and faced the hallway to

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the left. The recliner was against the wall.

In an interview with staff B on at approximately 9:30 AM who stated the resident was unable to sit up on a sofa, if she sat him on sofa, he would So they sat in on the recliner.

Continued observation noted that RS1, RS #3 and RS #4 were They sat in the common area on recliners with the feet elevated. The residents were unable to lower the recliner at will; they depended on the staff to grant them freedom to move about.

Observations on at approximately 12 PM noted RS #2 sat on the recliner. The recliner was leaned back and was in the same area as at 9 AM.

Observations at approximately 11:30 AM in # B noted there was a recliner on the right side of the Further observations noted there was a resident (#3) sleeping in a hospital behind the recliner. Staff B was called to the In an interview with staff B on at approximately 11:30 AM who stated the recliner was placed in front of the bed so resident # 3 would not out of bed. At the request of the Agency representative, she removed the recliner.

In an interview with the administrator on at approximately 3:30 PM, who stated the bed in had been grandfathered-in by the Agency. She was not aware that any device that prevents a resident from moving at will was a form of restrain. She stated she had no knowledge about the recliner in front of the bed of resident #3 while he slept.

Observation in the common area on the second floor on at approximately 12:15 PM the memory care unit revealed a staff member enter the common area with a brush in her and proceeded to brush resident #4's hair and then used the same brush to brush to other residents hair with the same brush.

On the administrator was asked to provide all of the resident's or family complaints/grievance for the year.

In an interview with resident #9 on at approximately 10:45 AM who stated "I tell them, the maintenance man is very good about fixing things. But the management, sometimes ignore you if they are too busy. He explained they never let you know the resolution of their investigation, relative your complaint. I asked them to move a resident from our table and I never got a response. She is still sitting at our table. You talk to the administrator and the owner and you get no response."

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During an interview with the administrator on [redacted] at approximately 2 PM, she stated that when residents/family had concerns she would resolve them and she was not aware that she had to have documentation of the resolutions. She further explained that the assistant administrator had written documentation of some of the residents' concerns and resolutions and she was off for the day and they did not have access to her documentation.

The administrator stated at the time, the family members of resident #6 had brought concerns to her and she had emails of her responses.

The administrator was given the opportunity to provide documentation of her responses to resident #6's family member via email and she did not provide any documentation of the responses/resolutions. There was no way to determine whether the administrator followed up on the resident/family concerns/complaints.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations, record review and interview the facility failed to ensure when unlicensed staff provided assistance with self-administration of medications, the staff followed the appropriate procedure at all times for 2 of 3 medication passes (#14 and #15).

Findings:

In an interview with staff B on [redacted] at approximately 9AM, who stated she was not a nurse.

Observations on [redacted] at approximately 12:30 PM during the medication pass on the memory care unit, noted that staff B retrieved a POD (A pharmacy filled bubble pod that contained all medications for that time of day) for resident #14 from the locked med cart. She brought the medications to where the resident sat. She told the resident "Your noon pills", she gave the resident water, observed her take the medications. She then signed the Medication Observation Record (MOR). The staff did not read the label to the resident.

Continued observations of the medication pass at approximately 12:30 PM noted staff B retrieved a POD for resident #15 from the unlocked med cart. She brought the medication package to where the resident sat. She put the pill in the resident's mouth and gave her juice. The resident pushed the pill out with her tongue. The staff put the pill back in the resident's mouth and gave her juice. She encouraged the resident to take the medication. The resident

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took the medication. She then signed the MOR. The staff did read the label to the resident and placed the medication in the resident's mouth.

In an interview on at approximately 4 PM with the administrator, who stated the staff knew better than that and when the resident spit-out the medication; should have been marked as refused.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations and interview the facility failed to ensure medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, or area at all times, out of sight of all residents.

Findings:

Observations on at approximately 12:30 PM during the medication pass on the memory care unit, noted that staff B obtained the medication packet for resident #14 from the locked med cart. She left the medication cart unlocked and went to assist resident #14 with the medications.

Continued observations of the medication pass at approximately 12:30 PM noted that staff B returned to the medication cart and obtained the medications for resident #15. In the meantime another staff noted the med cart was unlocked. She locked it and left the keys hanging from the key hole.

The medication pass was conducted on the memory care unit, in a common area where the memory care unit residents congregated to eat lunch.

In an interview on at approximately 4 PM with the administrator, who stated the staff knew better than to leave the cart unlocked, however another staff locked it.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on personnel record review and interview the facility failed to ensure all staff were assigned duties consistent with his/her level of education, training, preparation, and experience and allowed staff to administer medications to 1 of 3 sampled medication passes.

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Findings:

In an interview with staff B on at approximately 9 AM, who stated she was not a nurse.

Continued observations of the medication pass at approximately 12:30 PM noted that staff B obtained the medications for resident #15 from the unlocked med cart. Brought the medication package to where the resident sat. She put the pill in the resident's mouth and gave her juice. The resident pushed the pill out with her tongue. The staff put the pill back in the resident's mouth and gave her juice. She encouraged the resident to take the medication. The resident took the medication. She then signed the Medication Observation Record.

In an interview on at approximately 4 PM with the administrator, who stated the staff knew better than that and when the resident spit-out the medication; should have been marked as refused.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Cornerstone At Longwood (the)
480 East Church Avenue
Longwood, FL 32750

RE: CCR #20140003941

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2014 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 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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