STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968046	09/15/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Myrtice Angels Senior Home Care Llc	2570 Vernon St Jacksonville, FL 32209	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0160 - 58a-5.024(1) Fac - Records - Facility S-S= D

Specific Tag Findings:
0000-Initial Comments
An unannounced complaint survey, CCR#2014007190, was conducted at Myrtice Angels Senior Home Care, LLC, in Jacksonville, Florida, on 2014. Deficient practice was identified as a result of the survey.

0007-Admissions - Criteria 58A-5.0181(1) FAC
Based on record review and staff interview, the facility failed to ensure that a new admission was free from signs and symptoms of a communicable which might be transmitted to other residents or staff for 1 of 6 sampled residents. (Resident #3)

The findings include:

A review of Resident #3's chart revealed an admission date of A review of the Resident Health Assessment for Resident #3, which was dated by her physician revealed that she was to see her primary care physician within 2-3 weeks related to a positive RPR (Rapid Reagin), which was a screening test for There was no indication in Resident #3's chart that she had seen her primary care provider.

A review of the Resident Health Assessment for resident #3 which was dated and signed by a second physician on revealed that Resident #3 was being treated for and required contact isolation. Resident #3 was observed sitting in the living to all other residents throughout the course of the survey.

A interview with the administrator at approximately 6:00 p.m. revealed that she was unaware that this resident required contact isolation. She stated that all of her residents shared ms,and she had no provisions for isolating a resident. She also stated that were shared. The administrator was unable to address why Resident #3 had not seen her physician about her positive titer, but she placed a call to the hospital to have the resident removed from the facility until these issues had been addressed,

Class III

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review and staff interview, the facility failed to ensure that a Resident Health Assessment was completed by a licensed health care provider after a significant change for 1 of 3 sampled residents. (Resident #2)

The findings include:

A review of the clinical record for Resident #2 revealed that she was originally admitted to the facility on Diagnoses included The most current Resident Health Assessment was dated No new Resident Health Assessment was located in the chart following the resident's hospitalization. A handwritten note dated revealed that the resident had returned from the hospital on , but the

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hospital failed to send a new Resident Health Assessment. "I will contact them first thing in the morning." was noted by "L.C." (The owner/administrator) A review of the resident observation log indicated that on the resident went out to the hospital because she was not feeling well.

A interview with the administrator at 3:20 p.m. revealed that Resident #2 went to the hospital per her request, because "She was thinking about her baby and her husband and was depressed." When asked whether the administrator ever made the call to the hospital for a new Resident Health Assessment due to significant change and hospitalization, the administrator stated that she did call the hospital, but they never sent her a new Health Assessment.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record review and staff interview, the facility failed to ensure awareness of the general health and physical well-being for 1 of 6 sampled residents. (Resident #3) The facility failed to contact the residents' healthcare provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager of the resident exhibited a significant change in health status for 3 of 3 sampled residents. (Residents #1, #2 and #3) The facility also failed to maintain a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, or other changes that resulted in the provision of additional services for 2 of 3 sampled residents. (Residents #1 and #3)

The findings include:

1) A review of the Resident Health Assessment for Resident #3, which was dated by her physician revealed that she was to see her primary care physician within 2-3 weeks related to a positive RPR (Rapid Reagin), which was a screening test for There was no indication in Resident #3's chart that she had seen her primary care provider.

A review of the Resident Health Assessment for resident #3 which was dated and signed by a second physician on revealed that Resident #3 was being treated for and required contact isolation. Resident #3 was observed sitting in the living to all other residents throughout the course of the survey.

A review of the observation notes revealed that there was no indication that the responsible party or the primary care provider were made aware of the status of this resident. There was no documentation in the observation notes indicating that the staff was aware of resident #3's condition or what they were doing for her.

A interview with the administrator at approximately 6:00 p.m. revealed that she was unaware that this resident required contact isolation. She stated that all of her residents shared ms,and she had no provisions for isolating a resident. She also stated that were shared. The administrator was unable to address why Resident #3 had not seen her physician about her positive titer, but she placed a call to the hospital to have the resident removed from the facility until these issues had been addressed. She was not able to explain the lack of documentation related to Resident #3's health status.

2) A review of the clinical record for Resident #2 revealed that she was originally admitted to the facility on Diagnoses included The most current Resident Health Assessment was dated A review of the resident's observation log indicated that on the resident went out to the hospital because she was "not feeling well." There was no indication that her primary care physician or her

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brother,who was listed as her emergency contact were contacted when she went out to the hospital. Documentation in the observation notes dated and revealed that her brother was actively involved in her life.

A interview with administrator at 3:20 p.m. revealed that she went to the hospital because "She asked to go because she was thinking about her baby, and her husband and was depressed. When asked about the lack of documentation concerning notification of Resident #2's primary care physician and her brother (next of kin), the administrator did not respond.

3) A review of the clinical record for Resident #1 revealed that she was sent to the hospital following a on A review of the observation notes revealed that there was no documentation in the observation notes to indicate that anything occurred on or any date close to that date. Resident #1 was noted on the admission and discharge log as having gone to the hospital on and returned on No reason was noted. There was no documentation indicating that the resident's primary care physician was notified. There was no next of kin listed on the resident's face sheet.

During a interview with the administrator at approximately 6:00 p.m., she was unable to explain why there was no documentation in either Resident #1's or Resident #2's record annotating that the physician and responsible party/next of kin were notified. The administrator confirmed the lack of documentation in Resident #1's record pertaining to the that occurred on in which Resident #1 was sent out to the hospital.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, record review and interview, the facility failed to provide the recommended dietary allowances to each resident daily by not following the menu which was reviewed and approved annually by a registered dietitian. The facility failed to maintain adequate food stores to provide balanced meals per the facility's menu. The facility failed to maintain a 3-day supply of non-perishable food and water based on the number of weekly meals the facility had contracted with the residents to serve, and which must be on hand at all times. The facility also failed to maintain a current substitution log, or to post substitutions before or when the meal was served. This could potentially affect all 6 residents residing in the facility.

The findings include:

A tour of the facility on at 12:00 p.m. revealed inadequate food stores, no apparent emergency food or water supply, and the foods observed did not coincide with the posted menu. Upon arrival, no vegetables were observed in the facility. Two partial bags of grapes were observed in the refrigerator, and a can of peaches was observed. Otherwise, no fruit was observed. The owner/administrator arrived at approximately 1:00 p.m., and brought in groceries. Three large cans of fruit cocktail, three bunches of bananas and three bags of pre-cut salad were brought in at that time. No other fruits or vegetables were observed. (Photographic evidence obtained)

A review of the menu posted for the week (Week 2) indicated that the breakfast meal should include ¾ cup of citrus juice, 2 pancakes, 2 eggs cooked to order, 2 slices of bacon, and 8 oz. of low-fat milk.

An interview with Employee A at 12:40 p.m. revealed that she served coffee, toast and cereal for breakfast. Juice and eggs had been observed in the refrigerator. Pancake mix had been observed in the kitchen cabinet. There was no bacon or low-fat milk in the facility. There was whole milk in the refrigerator. Employee A was asked whether she had made the residents aware that there was a substitution of items from the menu. She said

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that she had not. Employee A was asked whether she had posted the change in the meal, and she replied that she had not. She was asked whether she had recorded the change on a substitution log, and she replied that she had not.

A review of the menu posted for the week (Week 2) revealed that lunch should have included a [redacted] cut sandwich with 2 oz. of assorted [redacted] cuts, 2 slices of bread, 2 slices of tomatoes, 2 lettuce leaves, ½ cup celery sticks, ½ cup carrot sticks and ½ cup applesauce.

A tour of the facility at approximately 12:00 p.m. revealed no tomatoes, no lettuce leaves, no celery or carrots and no applesauce.

An observation of the lunch meal at 3:35 p.m. revealed that the residents were served a bologna sandwich on white bread, a chocolate pudding cup, a donut stick, canned peaches, and juice to drink. This did not coincide with the menu.

At 3:40 p.m. the facility substitution log was provided for review. The most recent entry appeared to be noted on [redacted] Lunch - substituted turkey for ham and a fruit cup instead of cookies. There were no entries for [redacted]. The change in the lunch menu for [redacted] was not conveyed to the residents in any way. There was nothing posted, and the staff did not tell them verbally that there was a change in the menu prior to or at meal time.

Dinner for Week 2 on Monday night was noted as 1 1/2 cups Beef Stew, 1/2 cup rice, 1/2 cup mixed vegetables, 1 cup tossed salad, 1 dinner roll, 1/2 cup fruit cup, 3/4 cup fruit juice, 8 oz. low-fat milk, beverages, and condiments. No beef stew or ingredients for beef stew were observed, no vegetables were observed other than the bagged salad which arrived at 1:00 p.m. No rolls were observed, but bread came in at 1:00 p.m. with the administrator. There was no low-fat milk; only whole milk.

An interview with the administrator on [redacted] at approximately 6:30 p.m. revealed that snacks were provided to the residents daily. The administrator could not explain why the daily menu was not being adhered to. She confirmed that the facility lacked an adequate amount of food and water at the facility, to be used in the event of an emergency.

Class III

0160-Records - Facility 58A-5.024(1) FAC
Based on record review and staff interview, the facility failed to maintain a current admission and discharge log which indicated the location of a residents' discharges.

The findings include:

A [redacted] review of the admission and discharge log revealed that there was no documentation of a discharge location for any resident listed.

During a [redacted] interview with the administrator at approximately 6:30 p.m., she confirmed that the space on the forms for indicating a place of discharge was blank. She was unable to explain why that section was not completed.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Myrtice Angels Senior Home Care, LLC
2570 Vernon Street
Jacksonville, FL 32209

RE: CCR #2014007190

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2014 by a representative 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. Should you have any questions please call this office at .

Sincerely,

Jana Meyering

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JG/JM/sm
Enclosure

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