STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964889	09/10/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0026 - 58a-5.0182(2) Fac - Resident Care - Social & Leisure Activities 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 - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0080 - 58a-5.0191(1) Fac - Training - Core & Competency Test S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D
St - A - 0085 - 58a-5.0191(6) Fac - Training - Nutrition & Food Service S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0161 - 58a-5.024(2) Fac - Records - Staff S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D

Specific Tag Findings:

0000-Initial Comments
The biennial re-licensure with Limited Nursing Services (LNS) was conducted on Arbor cove had deficiencies found at the time of the visit,

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on observations, record review and interview the administrator failed to monitor the continued appropriateness of placement 1 of 3 sampled residents and retained the resident who required total care with bathing, dressing and and toileting which exceeded requirements for continued residency in the ALF (#1).

Findings:

In an interview with staff B on at approximately 9:45 AM , who stated resident # 1 needed total care with bathing , dressing, and toileting. The resident was dependent on staff.

Observations during the facility tour at approximately 9:30 AM noted the resident sat on a wheelchair and was

Resident record review on at approximately 2 PM for resident #2 revealed a health assessment report AHCA 1823 that listed diagnoses of high and wheelchair bound and needed total care with ambulation, dressing, toileting and transfers.

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In an interview on [redacted] at approximately 4 PM, with the administrator, who stated the resident, was able to transfers with assistance of two person but at times she would refuse to get up. She added the resident's family wanted her in the facility, not any place else. The administrator asked the resident to transfers from the wheelchair to a chair; the resident refused. When asked about the resident s ability to assist with bathing, dressing and toileting the administrator replied that she would speak with the resident's daughter.

Class III

0026-Resident Care - Social & Leisure Activities 58A-5.0182(2) FAC
Based on observations and interviews the facility failed to ensure residents were provided activities at least 6 days a week for a total of not less than 12 hours per week.

Findings:

In an interview with staff B on [redacted] at approximately 9:45 AM, who stated "We have activities one (1) hour, once a week."

In an interview with staff C on [redacted] at approximately 10:30 AM, who stated "We have activities on Tuesdays."

In an interview with staff D on [redacted] at approximately 11 AM, who stated "We don't' have activities."

Observations on [redacted] at approximately 11 AM a group of individuals came in to do activities. They talked about Kuala bears, watched a short video about Kuala bears and did coloring. The residents enjoyed it. The activities ended at approximately 12 PM.

Observation of the activities calendar posted by the living [redacted] the following activities for Wednesday [redacted] Devotions, hymns-sing- along, walk with a friend, bingo and exercise [redacted] The calendar listed several activities every day of the week but the hours were not indicated.

In an interview with resident #3 on [redacted] at approximately 1 PM, who stated "No there is no activities here, nothing to do. I watch TV, I like dominos but no one wants to play". The only activities are what you saw today."

In an interview with resident #4 on [redacted] at approximately 11:30 AM, who stated "No

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activities. There is a lady that comes here. It's Ok with me. I have my TV, if there were more activities I would participate."

In an interview with resident #5 on [redacted] at approximately 9:30 AM, who stated "No there is nothing to do, only once a week on Wednesday for hour only."

In an interview on [redacted] at approximately 4 PM with the administrator, who stated the facility did offer activities.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observations the facility failed to ensure the unlicensed staff that assisted with self-administration of medications followed the correct procedure when she provided assistance with self-administration to 3 of 3 random sampled residents (RS#6, 7, and 8).

Findings:

Observations on [redacted] at approximately 12:45 PM during the medication pass noted the following:

Staff C washed her hands. She retrieved the medications from the locked medication cart. She left the medication cart ajar. She took the medications to where RS# 6 sat at the dining table. The resident sat at the dining table with 4 other residents. She placed the medications on the table and went to kitchen to get water. She told the resident "(Name) you take this one". She poured the medication in a plastic cup and then in a spoon. One pill [redacted] to the floor. She picked the pill up and placed it back on the spoon. She fed the medications to the resident; she waited until the resident swallowed the pills and signed the Medication Observation Record (MOR). She returned the medication to the unlocked medication cart.

Continued observations of the medication pass noted that Staff C retrieved the medications from the unlocked medication cart. She took the medications to where RS #7 sat at the dining table. The resident sat at the dining table with 3 other residents. She placed the medications on the table and went to kitchen to get pudding. She crushed the medications and mixed them with pudding in a plastic cup. She fed the medications to the resident. She waited until the resident swallowed the pudding and signed the MOR. She returned the medication to the unlocked medication cart.

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She retrieved the medications for RS #8. She crushed her medications and left them on top of the dining table where 3 residents sat. She went to the kitchen to get pudding. She mixed the medications with the pudding and told the resident it was . The resident refused the spoonful of pudding and stated she did not need any . The staff told the resident that it was her medicine; the resident refused and said "You said it was . The staff asked the resident if she wanted desert. The resident said yes. The staff poured the pudding with medication in a bowl with more pudding and gave it to the resident. At this point the Registered Nurse (RNS) intervened and told the staff to stop. The administrator who is a registered nurse was called to the area. She was in her office. The observation was explained to the administrator. She asked the resident if she wanted her medications, the resident said no. The nurse told the staff, she refused her medications and took the pudding with the medications away. The resident was given another bowl of pudding.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on observations, record review and interview the facility failed to ensure medication administration was provided by a licensed nurse for 3 of 3 random sampled residents (RS# 6, 7, and 8) and 1 sampled resident (#3), who were unable to assist with self -administration of medications.

Findings:

Observations on at approximately 12:45 PM during the medication pass noted the following:

Staff C washed her hands. She retrieved the medications from the locked medication cart. She left the medication cart ajar. She took the meds to where RS# 6 sat at the dining table. The resident sat at the dining table with 4 other residents. She placed the meds on the table and went to kitchen to get water. She told the resident "(Name) you take this one". She poured the medication in a plastic cup and then in a spoon. One pill to the floor. She picked the pill up and placed it back on the spoon. She fed the medications to the resident.

Continued observations of the medication pass noted that Staff C retrieved the medications from the unlocked medication cart. She took the meds to where RS #7 sat at the dining table. The resident sat at the dining table with 3 other residents. She placed the meds on the table and went to kitchen to get pudding. She crushed the medications and mixed them with

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pudding in a plastic cup. She fed the medications to the resident; she waited until the resident swallowed the pudding.

She retrieved the medications for RS #8. She crushed her medications and left them on top of the dining table where 3 residents sat. She went to the kitchen to get pudding. She mixed the medications with the pudding and told the resident it was . The resident refused the spoonful of pudding and stated she did not need any . The staff told the resident that it was her medicine; the resident refused and said "You said it was a . The staff asked the resident if she wanted desert. The resident said yes. The staff poured the pudding with medication in a bowl with more pudding and gave it to the resident. After observing the above staff C was asked to stop the medication pass. The administrator who was registered nurse was called to the area. It was explained to the administrator what transpired with the last med pass. She asked the resident if she wanted her medications, the resident said no. The nurse told the staff, she refused her meds and took the pudding with the medications away. The resident was given another bowl of pudding.

Personnel record review on at approximately 3:30 PM revealed staff C was not a licensed health care professional, therefore she not able to administer medications to the residents.

During an interview with administrator on at approximately 4 PM revealed the staff had been trained on providing assistance with self-administration of medications.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC
Based on observations and interview the facility failed to ensure centrally stores medications were secure at all times.

Findings:

Observations on at approximately 12:45 PM during the medication pass noted that staff C left the medication cart ajar and medications unattended while residents sat nearby.

She retrieved the medications from the locked medication cart. She left the medication cart ajar. She took the medications to where RS# 6 sat at the dining table. The resident sat at the

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dining table with 4 other residents. She placed the medications on the table and went to kitchen to get water. After the resident took the medications she returned the medication to the unlocked medication cart.

Staff C and the administrator were made aware that the medication cart was ajar.

Continued observations of the medication pass noted staff C retrieved the medications from the unlocked medication cart. She took the medications to where RS# 7 sat at the dining table. The resident sat at the dining table with 3 other residents. She placed the medications on the table and went to kitchen to get pudding. After the resident took the medications she returned the medication to the unlocked medication cart.

Observations continued revealed the medication cart remained unlocked.

She retrieved the medications for RS#8. She crushed her medications and left them on top pf the dining table where 3 residents sat. She went to the kitchen to get pudding. After the resident took the medications she returned the medication to the unlocked medication cart.

In an interview with the administrator on ..... at approximately 1 PM revealed she had spoken to the staff.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on observations, records review and interviews the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation and experience and allowed unlicensed staff to administered medications that included .... sugar testing to 3 of 3 random sampled residents (RS# 6, 7 & 8) and 1 sampled resident (#3).

Findings:

In an interview on ..... at approximately 10:30 AM, staff C stated she assisted resident #3 with his .... pen and the .... sugar testing. She stated she assisted him with the ..... pen for him. "I put the units on; I do his .... sugar too. I assist him".

Observations on ..... at approximately 12:45 PM during the medication pass noted the

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following:

Staff C washed her hands. She retrieved the medications from the locked medication cart. She left the medication cart ajar. She took the meds to where RS# 6 sat at the dining table. The resident sat at the dining table with 4 other residents. She placed the meds on the table and went to kitchen to get water. She told the resident "(Name) you take this one". She poured the medication in a plastic cup and then in a spoon. One pill fell to the floor. She picked the pill up and placed it back on the spoon. She fed the medications to the resident; she waited until the resident swallowed the pills and signed the MOR. She returned the medication to the unlocked medication cart.

Continued observations of the medication pass noted staff C retrieved the medications from the unlocked medication cart. She took the meds to where RS #7 sat at the dining table. The resident sat at the dining table with 3 other residents. She placed the meds on the table and went to kitchen to get pudding. She crushed the medications and mixed them with pudding in a plastic cup. She fed the medications to the resident; she waited until the resident swallowed the pudding and signed the MOR. She returned the medication to the unlocked medication cart.

Observations continued revealed the medication cart remained unlocked.

She retrieved the medications for RS#8. She crushed her medications and left them on top of the dining table where 3 residents sat. She went to the kitchen to get pudding. She mixed the medications with the pudding and told the resident it was [redacted]. The resident refused the spoonful of pudding and stated she did not need any [redacted]. The staff told the resident that it was her medicine; the resident refused and said "You said it was a [redacted]. The staff asked the resident if she wanted desert. The resident said yes. The staff poured the pudding with medication in a bowl with more pudding and gave it to the resident. Staff C was asked to stop the medication pass and the administrator was called to the area and informed of the above. The administrator was informed what transpired during the medication pass. She asked the resident if she wanted her medications, the resident said no. The nurse told the staff she refused her meds and took the pudding with the medications away. The resident was given another bowl of pudding.

In an interview on [redacted] at approximately 1PM with resident #3 who stated the staff was kind to him and that "Well I was told that the [redacted] was changed to nighttime. This morning we

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had a misunderstanding. They are supposed to check my sugar every morning before I eat and she came late. She also gives me the [illegible] at night."

Personnel record review on [illegible] at approximately 3:30 PM revealed staff C was not a licensed healthcare professional and not allowed to administer medications.

Class III

0080-Training - Core & Competency Test 58A-5.0191(1) FAC
Based on personnel record review and interview the administrator failed to have evidence of 12 hours of continuing education in topics related to Assisted Living every 2 years.

Findings:

Personnel record review on [illegible] at approximately 3:30 PM for staff A (the administrator) revealed that there was no documentation to confirm that she had completed 12 hours of continuing education in topics related to Assisted Living every 2 years.

In an interview on [illegible] at approximately 4 PM with the administrator, who stated she needed to obtain the continuing education requirements.

Class III

0083-Training - First Aid and [illegible] 58A-5.0191(4) FAC
Based on personnel record review and interview the facility failed to ensure that a staff member who had First Aid certification and Cardio-puln [illegible] offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American [illegible] Association, or National Safety Council; or a provider approved by the Department of Health was in the facility at all times when residents were present.

Findings:

During the facility entrance on [illegible] 14 at approximately 9 AM staff B identified and staff C, D and herself as the caregivers present. The administrator, a Registered Nurse was not in the facility. The staff called her. She arrived about an hour later.

Staff schedule review on [illegible] at approximately 2 PM revealed staff B worked 7 days a week from 8 AM to 6 PM. Staff B and C worked from 6 PM to 8 AM and were lived-in staff.

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Personnel record review on [redacted] at approximately 3 PM revealed that staff B, who worked 8 AM to 6 PM revealed a First Aid and [redacted] certification that expired on [redacted] The certificate indicated the course was taken on line (Internet) not in a [redacted] in the presence of an instructor.

Staff C, who worked 8 PM to 6 AM (lived in) revealed a First Aid and [redacted] certification that expired on [redacted] The certificate indicated the course was taken on line (Internet) not in a [redacted] in the presence of an instructor

Staff D, who worked 8 PM to 6 PM (lived-in) revealed no evidence to confirm First Aid and [redacted] certification training.

In an interview with on [redacted] at approximately 4 PM with the administrator, who stated she did not know that on-line [redacted] and First Aid courses were not accepted by the Agency.

Class III

0085-Training - Nutrition & Food Service 58A-5.0191(6) FAC
Based on record review and interview the facility failed to ensure the person in charge of food services (staff A) completed 2 hours of continuing education annually in topics pertinent to nutrition and food service.

Findings:

In an interview on [redacted] at approximately 1 PM with staff A, who stated she was the person responsible for the facility's food service.

Personnel record review on [redacted] at approximately 3:30 PM for staff A (the administrator) revealed that there was no documentation to confirm that she had completed 2 hours of continuing education annually regarding nutrition and food service in an assisted living facility.

In an interview on [redacted] at approximately 4 PM with the administrator, who stated she needed to obtain the continuing education requirements.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observations, interviews and facility menu review the facility failed to ensure that regular and therapeutic menus as served, with substitutions noted before or when the meal

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was served and kept on file in the facility for 6 months and a 3-day supply of nonperishable food, that included water was on hand and available at all times.

Findings:

Observations on at approximately 11:30 AM noted the menu posted on the refrigerator, in the kitchen, listed Grilled fish, fried rice, spinach and cantaloupe and ice tea. Continued observations noted the staff prepared a different meal. In an interview with staff A and C on at approximately 11:30 AM who stated the menu served today for lunch was and onions, macaroni, mixed vegetables and pudding. The day before the lunch menu to be served was roast turkey; stuffing, green beans and apple pie. However, fish, rice and beans, mixed vegetables and bread pudding was served. Staff A and C stated the foods needed for the menu were not available; therefore they made what they had.

They did not write the substitutions down. Staff A stated she just keeps the information in her

During the facility tour on at approximately 9 AM staff A stated the census was 11 residents.

Observations on at approximately 12 PM of the facility's emergency food supply noted there was a 5 gallon bottle of water. In an interview with the administrator on at approximately 12:30 PM who stated she had a letter from Culligan Water that indicated they will deliver water to the facility in the event of an emergency. Review of the letter revealed it was dated Review of the Emergency Management Plan revealed the plan was approved on prior to the agreement with the water delivery company.

The facility census was 11 residents. Based on a census of 11 residents the facility needed 11 (resident) x 1 (gallon) x 3 (days), for a total of 33 gallons.

In an interview on at approximately 12 PM, with the administrator stated she thought that the water delivery service contract was good enough. She was not aware that the agreement should have been submitted to the Emergency Management Agency to review along with the plan.

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0161-Records - Staff 58A-5.024(2) FAC
Based on interview the facility failed to ensure personnel record for 1 of 4 sampled staff records contained all the mandated documentation (D).

Findings:

In an interview with staff D on at approximately 11 AM, who stated she assisted the facility residents with self-administration of medications.

Personnel record review on at approximately 3 PM for staff D revealed the Employment application with references, First Aid and certification and the initial 4 hours regarding assistance with self-administration of medication were not available for review.

In an interview with on at approximately 4 PM with the administrator, who stated the staff works somewhere else as well and had the training but did not bring in the certificates. She was unable to locate her application for employment.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on observations, record review and interview the facility failed to ensure that 1 of 3 sampled residents (#1) who received assistance with the activities of daily living had her weight recorded semi-annually.

Findings:

Observations on at approximately 9:30 AM noted resident #1 sat in a wheelchair in the living The resident was identified by staff B as being under the care of hospice.

Resident record review at approximately 2:15 PM for resident #1 revealed a health assessment report dated listed diagnoses of high and Continued review revealed the assessment indicated the resident needed total care with ambulation, transferring, toileting, and dressing. Continued review revealed she was admitted to hospice on The last documented weight record was dated 2010.

In an interview with the administrator on at approximately 3 PM, regarding the resident's weight record, she stated hospice did body index and she thought that met the

requirement for weights and there were no weights taken by the facility as the resident was unable to stand.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Arbor Cove
305 North Hiawassee Rd
Orlando, FL 32835

RE: Biennial relicensure w/LNS

Dear Administrator:

This letter reports the findings of a state licensure 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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