STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967269	10/27/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Zion's Ii Assisted Living, Inc	256 Barbarossa Rd Nw Palm Bay, FL 32907	
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 - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0032 - 58a-5.0182(8) Fac - Resident Care - Elopement Standards 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 - 0056 - 58a-5.0185(7) Fac - Medication - Labeling And Orders S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D

Specific Tag Findings:
0000-Initial Comments
A Change of Ownership (CHOW) survey was conducted to a revisit on Zion II Assisted Living had deficiencies found at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on interview and record review the facility failed to ensure the health assessment contained all required information for 3 of 4 sampled residents record (#2, #4 and #5).

Findings:

1. Resident record review on at approximately 2:30 PM revealed resident #2 had a health assessment report dated Further review revealed an assessment did not address the resident's needs regarding assistance with self -administration of medications.

2. Resident #4 had a health assessment report dated that did not address the resident's needs regarding assistance with self -administration of medications.

3. Resident #5 had a health assessment report dated that did not address the resident's needs regarding assistance with self -administration of medications; it was blank.

In an interview with the administrator on at approximately 4 PM who stated the information had been overlooked.

Class III

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0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review and interview the facility failed to ensure that as part of the continued residency 1 of 4 sampled residents (#1) who experienced a significant change, had a face-to-face medical examination by a health care provider when she was admitted to hospice services.

Findings:

Resident record review on at approximately 2:30 PM revealed resident #1 was admitted to hospice on Continued individual record review revealed an updated health assessment report 1823 was not available for review. The assessment available for review was dated

In an interview with the administrator on at approximately 4 PM who stated the assessment was overlooked.

Class III

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observations, record review and interview the facility failed to ensure it provided care and services appropriate to the needs of 1 of 4 sampled residents (#4) and did not follow the healthcare provider's order for a medication.

Findings:

Observations of the medication pass at approximately 12 PM noted staff A, assisted resident #4 with self-administration of medications. She retrieved one packet of the medication from the locked medication cupboard. She told the resident what the medication was, opened the packet and told the resident to pour it in her drink. The resident did. The staff stated she would not sign the Medication Observation Record (MOR) until the cup was empty. She did not stay with the resident to observe her take all the medication. The prescription label dated indicated 4 milligrams (mg) take 1 packet and dissolve and take 4 times daily.

Resident record review on at approximately 3:15 PM revealed a prescription dated that indicated 4 mg 1 scoopful twice a day. The 2014 MOR listed 4 milligrams (mg) take 1 packet and dissolve and take 4 times daily and was given at 8 AM, 12 PM, 5 PM and 7 PM.

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In an interview with the administrator on [redacted] at approximately 4 PM, who stated she was not aware of the revised order from [redacted].

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 the use of physical restrains was limited to half-bed rails only for 2 of 4 sampled resident (#1 & #3) did not give the residents of the facility consideration by notifying them in writing when the facility ownership changed pursuant to 429.12(1) Florida Statue.

Findings:

Observations during the facility tour on [redacted] at approximately 9:30 AM, noted residents #1 and #3 had half-bed rails in use on their beds. The residents were [redacted] and under hospice services.

1. Resident record review on [redacted] at approximately 2:30 PM revealed that resident #1 had a half-bed rail order dated [redacted]. A revised order was due [redacted].

2. Resident #2 had a half-bed rail order dated [redacted]. A revised order was due every 6 months thereafter.

Continued individual record review revealed that an updated health care provider order was not available for review.

Individual resident record review revealed no evidence to confirm the residents and/or representatives were notified in writing on the change of ownership.

In an interview with the administrator on [redacted] at approximately 4 PM who stated the orders were overlooked.

Class III

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC
Based on observations, record review and interview the facility failed to ensure 1 of 4 sampled

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residents (#4) who was identified as elopement risk by the healthcare provider had identification on her person at all times and failed to have a photo of the resident available to staff.

Findings:

Observations of resident #5 on at approximately 10:15 noted she did not have any type of identification on her person. The resident ambulated independently through the facility.

Resident record review for resident #4 on at approximately 2:30 PM revealed a health assessment report form 1823 dated that indicated diagnoses of high and The assessment indicated she was at risk of elopement.

In an interview with the administrator on at approximately 4 PM who stated the resident was not an elopement risk, the resident's son had asked the doctor to indicate she was at risk. She had no identification on her nor was a photo available.

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 1 of 2 sampled residents (#2) with self-administration of medications followed the correct procedure.

Findings:

Observations of the medication pass at approximately 12 PM noted staff A, assisted resident #4 with self-administration of medications. She retrieved one packet of the medication from the locked medication cupboard. She told the resident what the medication was, opened the packet and told the resident to pour it in her drink. The resident did. The staff stated she would not sign the Medication Observation Record (MOR) until the cup was empty. She did not stay with the resident to observe her take all the medication. The prescription label dated indicated 4 gm take 1 packet and dissolve and take 4 times daily.

In an interview with the administrator on at approximately 4 PM, who stated she did not realize the staff did not follow all the correct steps.

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on interview and record review the facility failed to have a nurse available to administer medications to 1 of 4 sampled residents (#1) who needed medications administered.

Findings:

Observations during the facility tour on at approximately 9:30 AM, noted the resident had half-bed rails in use on her bed. The resident was and under hospice services.

Observations on at approximately 12 PM noted the resident was in bed and was fed by staff a puree diet.

Resident record review on at approximately 2:30 PM revealed a health assessment dated that listed diagnoses of and An order dated indicated to puree all foods and medications.

In an interview with the administrator on at approximately 4 PM who stated the resident really could not feed herself so the staff did it for her. The administrator was asked if the she was able to put a cup with crushed medications in her mouth or was she able to use a spoon, the administrator stated no she cannot.

Class III

0056-Medication - Labeling and Orders 58A-5.0185(7) FAC
Based on observations, record review and interview the facility failed to ensure that when directions for use were "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions, limitations must be specified. The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.

Findings:

Observations during a medication pass on at approximately 12 for resident #5 was noted to take a inhaler HFA 108 mcg and took one puff. The prescription label was

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and indicated take 1 puff every 4 to 6 hours. The label did not indicate under what circumstances was the inhaler to be used 4 to 6 hours.

The health assessment report 1823 dated listed a diagnosis of and indicated Inhaler one puff as needed. An order dated but not signed by doctor indicated 0.088 % inhalation as needed. The 2014 Medication Observation Record listed the inhaler medication and was taken as necessary/as needed at 8 AM, 12 PM, 2 PM 4 PM, 8 PM, 10 PM, 12 AM, 2 AM and 6 AM. Continued review revealed that a revised order that indicated revised instructions and limitations for use were not available.

In an interview with the administrator on at approximately 4 PM who stated a revised order was not available.

Class III

0078-Staffing Standards - Staff 58A-5.019(2) FAC
Based on observations, 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 unlicensed staff to administer medications to 1 of 4 sampled residents (#1).

Findings:

Observations during the facility tour on at approximately 9:30 AM, noted resident #1 had half-bed rails in use on her bed. The resident was and under hospice services.

Observations on at approximately 12 PM noted the resident was in bed and was fed by staff a puree diet.

Resident record review on at approximately 2:30 PM revealed a health assessment dated that listed diagnoses of and An order dated indicated to puree all foods and medications.

In an interview with the administrator on at approximately 4 PM who stated the resident really could not feed herself so the staff did it for her. The administrator was asked if the resident was able to put a cup with crushed medications in the mouth or was she able to

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use a spoon, the administrator stated no she cannot.

Class III

0083-Training - First Aid and 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 offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American 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:

Personnel record review on at approximately 3 PM revealed that staff #B was a caregiver. Continued review revealed a First Aid certificate that expired on Further review of the certificate revealed she had attended an on line Fist Aid Certification class on The trainer was the American Academy of and First Aid. The certificate indicated she passed in accordance with their requirements.

Personnel record review on at approximately 3PM for staff D revealed a certificate dated from PRO, an on- line training service. The certificate indicated she passed in accordance with their requirements and expired

In an interview with the administrator on at approximately 4 PM, who stated she was not aware that on -line First Aid and were not acceptable.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Zion's II Assisted Living, Inc
256 Barbarossa Rd Nw
Palm Bay, FL 32907

RE: Change of Ownership (CHOW)

Dear Administrator:

This letter reports the findings of a state licensure CHOW 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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