STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968435	12/17/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Rose Garden Manor	34731 Chancey Rd Zephyrhills, FL 33541	
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 S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And , S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

An Extended Congregate Care (ECC) monitoring survey was conducted on .

Rose Garden Manor, assisted living facility, had deficiencies found at the time of the visit.

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

Based on observation, interview and record review the facility failed to follow basic medication self-administration principals by having the facility manager pre-pour medications in a resident labeled cup for a caregiver to give to the residents the next morning.

Findings Include:

On the facility was entered at 9:05 a.m. to conduct a monitoring visit. A sole caregiver (A) was found on duty providing direct care to 5 facility residents. The caregiver stated that he had been the sole caregiver on duty since 5:00 p.m. on .

At 9:10 a.m. the caregiver was observed bringing a plastic drinking cup with a resident's name on the cup and give the cup to the resident. He did not tell the resident what the medications were. The resident (#1) refused to take the medications and the caregiver took the cup back to the office and placed the cup on a shelf . The cup contained 4 pills. When the caregiver was asked what the pills were he stated he did not know. He further stated that the facility manager would put the morning pills in cups labeled with the residents' names for him to give to the residents in the morning. He confirmed that he did not prepare the medications in the cups, nor did he mark the Medication Observation Record noting the resident's refusal to take her morning medications.

An observation of the mecication storage closet (which was left unlocked) in the open office directly off the dining the residents were sitting, revealed there were 3 cups with pre-poured medications for residents #1, 2 and 3. Two of the cups labeled with resident #4 and 5 were empty.

At 9:35 a.m. resident #3 entered the dining l after the resident was seated at the kitchen counter, the caregiver again went to the closet and obtained a cup with resident #3's name on it. Before he handed the cup to the resident the caregiver was asked what medications he was giving and he stated "I don't know there are 9 or 10 pills in the cup." He proceeded to give the cup to the resident who took the medications. The care giver returned the cup to the still unlocked office medication closet.

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The owner/administrator arrived at 9:45 a.m. and was told of the observation. She stated "I don't know why she (the facility manager) did that. He took his med tech (medication self-administration) training last week with our pharmacist." The 4 hour training certificate was reviewed.

When the facility manager arrived at 10:30 a.m. the owner/administrator asked her why the medications were pre-poured. The facility manager stated "I thought I was helping him out until the pharmacist could come out to help him. I know we're not supposed to do that. It was wrong."

CLASS III

PATTERN

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

Based on observation and interview the facility failed to ensure the medication storage closet located in the facility office next to the dining area was kept locked at all times when a staff person was not in the office.

Findings Include:

On the facility was entered at 9:05 a.m. to conduct a monitoring visit. A sole caregiver (A) was found on duty providing direct care to 5 facility residents. The caregiver stated that he had been the sole caregiver on duty since 5:00 p.m. on .

An observation was made of the medication storage closet at 9: 25 a.m. in the open office directly off the dining the residents were sitting. The closet door was unlocked and the medication closet was left open. There were cups with pre-poured medications as well as baskets and containers with all of the resident medications on the shelves of the closet.

The sliding pocket door from the dining the office was open. At 9:30 a.m. resident #1 was observed walking into and across the office to use the on the other side of the office. The resident was noted to have some . The resident then exited the the office again. The caregiver on duty was providing breakfast to other residents at the time.

The owner/administrator entered the facility at 9:45 a.m. The med storage closet was still open until the facility manager arrived at 10:45 a.m. Both staff persons were advised of the resident going through the office to the . The owner/administrator then stated "She is very and will try to open any door she comes to." It was then pointed out that the medication storage closet was still open and could have been accessed by the resident. Attempts were made to engage the lock on the medication storage closet door without success. The owner/administrator confirmed the closet should be locked at all times when not being accessed by staff.

CLASS III

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0083-Training - First Aid and **58A-5.0191(4) FAC**

Based on interview and record review the facility failed to ensure a sole caregiver (A) responsible for direct care to 5 facility residents from 5:00 p.m. to 8:00 a.m. had current valid certification in First Aid and [illegible] ( ).

Findings Include:

On the facility was entered at 9:05 a.m. to conduct a monitoring visit. A sole caregiver was found on duty providing direct care to 5 facility residents. The caregiver stated that he had been the sole caregiver on duty since 5:00 p.m. on . He further stated that he worked either 24 or 48 hour shifts by himself except between the hours of 8:00 a.m. to 5:00 p.m. when the owner/administrator and/or the facility manager were also in the facility. From 5:00 p.m. to 8:00 a.m. he was alone providing resident care. He was asked to contact the owner/administrator and/or the facility manager and advise them that a monitoring survey was in process at 9:15 a.m. The owner/administrator arrived at 9:45 a.m. The facility manager arrived at 10:30 a.m.

A review of staff person A's employment record was conducted with the owner/administrator. She confirmed the caregiver's work hours and schedule as detailed above. The caregiver's date of hire was . The owner/administrator was asked to provide proof of that caregiver A was certified in and First Aid. She was unable to find the information in the caregiver's file.

The facility manager was asked by the owner/administrator after she had arrived to find the and First Aid cards. She stated "He is scheduled to go with me next week to take the course. My First Aid and are expired." She confirmed that care giver A did not have current First Aid and certification.

CLASS III

[illegible]

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on interview and record review the facility failed to obtain a background screening on one (A) of 4 facility employees who provided direct care to 5 elderly residents. Failure to ensure residents receive care and services safely, securely and from persons who have not committed offenses that preclude them from employment, directly placed the residents at risk for exposure to persons whom the Florida Legislature has deemed inappropriate to provide care and services.

Findings Include:

On the facility was entered at 9:05 a.m. to conduct a monitoring visit. A sole caregiver was observed on duty providing direct care to 5 facility residents. The caregiver stated that he had been the sole caregiver on duty since 5:00 p.m. on . He further stated that he worked either 24 or 48 hour shifts by himself except between the hours of 8:00 a.m. to 5:00 p.m. when the owner/administrator and/or the facility manager were also in the facility. From 5:00 p.m. to 8:00 a.m. he was alone providing resident care. He was asked to contact the owner/administrator and/or the facility manager and advise them that a monitoring survey was in process at 9:15 a.m. The owner/administrator arrived at 9:45 a.m. The facility manager arrived at 10:30 a.m.

A review of staff person A's employment record was conducted with the owner/administrator. She confirmed the

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caregiver's work hours and schedule as detailed above. The caregiver's date of hire was / /. The owner/administrator was asked to provide proof of an eligible result from an Agency background screening. She was unable to provide the result and stated "I know I told him to get it. I just don't know where it is."

An on-line search of the Background Screening clearinghouse website was conducted at 10:15 a.m. The staff person was found on the search site, however, the results posted stated "A new screening is required." A further note indicated that there were no fingerprints on file. The owner/administrator repeated that "He was told to get the fingerprints done and we told him where to go. It's the same place we have all gone to."

When the facility manager arrived at 10:30 a.m. she was advised of the findings and stated "I sent him to get his fingerprints done but he went to the police department to have his fingerprints taken even though I told him where he needed to go. I guess he still didn't get the fingerprints done."

Caregiver A had been employed and providing direct care to residents over a 24 day period without a valid eligibility background screening. Per the owner/administrator he would not be allowed to work until they received a clear background screening result. The caregiver was asked to leave the facility and staff person B (with an eligible background screening) was contacted to work in staff person A's place.

UNCLASSIFIED

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Rose Garden Manor
34731 Chancey Rd
Zephyrhills, FL 33541

Dear Administrator:

This letter reports the findings of a Extended Congregate Care (ECC) monitoring visit 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 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 **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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