STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966430	12/30/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Gentle Care Assisted Living, I	66 Blare Castle Drive Palm Coast, FL 32137	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D
St - A - 0162 - 58a-5.024(3) Fac - Records - Resident S-S= D
St - A - 0167 - 58a-5.025 Fac - Resident Contracts S-S= D

Specific Tag Findings:

0000-Initial Comments
An unnanounced biennial licensure survey was conducted at Gentle Care Assisted Living on .

Deficiencies were identified.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC
Based on a review of resident records, and interview with the Administrator, the facility failed to obtain complete information on the ACHA form 1823 (Resident Health Assessment) for 1 of 2 sampled residents whose records were reviewed (Resident #5).

The findings include:

A record review conducted for Resident #5 found a Resident Health Assessment dated . On page one of the assessment, the sections to include the height and weight of the resident were left blank. In addition, the examiner did not complete the assessment to identify the or behavioral needs of the resident, any nursing services or treatment needs, or special precautions to be taken.

An interview was conducted with the Administrator at 12:15 pm on . She reviewed the record and confirmed the missing information.

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC
Based on observations, personal file reviews, and interviews with staff, the facility Administrator failed to provide responsible oversight of the facility's operations, and of the staff who provided care to the residents residing within.

The findings include:

1. A personnel file review for Employee A found she was hired in 2014 (no day noted) as a caregiver. Further review of the record found missing documentation from a health care provider that she was free from communicable , including .

A personnel file review for Employee A found she was hired on 12/10/13 as a Certified Nursing Assistant. Further review of the record found no documentation by a health care provider that she was free from communicable

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There was no annual documentation of freedom from for this employee.

2. An observation of Resident #4 was conducted during the tour of the facility at 9:40 am on She was in her bed, with the head of her bed elevated. She had a nasal canula in place, and a concentrator at bedside that was delivering at a rate of 2.5 liters per minute.

An interview was conducted with the Administrator at 10:00 am on When asked who managed the for Resident #4, she stated hospice came in once weekly and performed this service. She explained that Resident #4 received continuous and when hospice was not in the facility, she herself would make sure it was running, and the nasal canula in place. She stated Resident #4 sometimes pulled the canula out. She also stated she had to turn the concentrator on and off.

An interview was conducted with Resident #3 at 10:46 am on She handed this surveyor a sheet of paper that indicated she was to wear hose (compression stockings) daily. The directions for use were "on in the morning and off at bedtime." Resident #3 pointed to the the stockings, which were hanging on her closet door. When asked if she could put them on and take them off on her own, she said "No." She stated Employee A did this for her.

An interview was conducted with Employee A at 11:23 am on She confirmed she had to place the compression hose on for Resident #3 on a daily basis after her shower. She also stated she turned on the concentrator for Resident #4, and made sure the canula was in place, as the resident often removed it.

A personnel file review conducted for Employee A found she was hired in 2014 as a caregiver. Further review found she had no license to provide assistance with or the application of compression stockings.

An interview with the Administrator was conducted at 2:15 pm on She acknowledged that unlicensed staff were not permitted to assist with provision of skilled services for Resident #3 or Resident #4.

3. A personnel file review was conducted for Employee A found she was hired in of 2014. There was no documentation that Employee A received the required training in the facility's policy and procedures for emergencies.

A personnel file review conducted for Employee B, hired found no evidence she received the required training in the facility's emergency procedures, incident reporting, or resident rights. In addition, Employee B, who was the full-time overnight staff, had no current certification in The Level 2 eligibility for Employee B was dated almost eight months prior to hire. The employment application did not indicate dates of her prior employment, and there was no indication of whether a 90 day gap in employment had occurred prior to her hire.

An interview was conducted with the Administrator at 1:15 pm on She acknowledged the requirements for a re-screening prior to hire for Employee B. She confirmed the missing trainings for Employees A and B.

Class III

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0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on a review of resident records, and interview with the Administrator, the facility failed to obtain a statement of freedom from communicable and an annual statement of freedom from for 2 of 3 sampled employees (Employees A and B). In addition, the facility failed to ensure: that 2 of 3 sampled employees (Employees A and C) were licensed to perform skilled services in the facility; and that 2 of 3 sampled employees (Employees A and B) completed all required trainings.

The findings include:

1. A personnel file review for Employee A found she was hired in 2014 (no day noted) as a caregiver. Further review of the record found missing documentation from a health care provider that she was free from communicable including

A personnel file review for Employee B found she was hired on as a Certified Nursing Assistant. Further review of the record found no documentation by a health care provider that she was free from communicable

2. An observation of Resident #4 was conducted during the tour of the facility at 9:40 am on She was in her bed, with the head of her bed elevated. She had a nasal canula in place, and a concentrator at bedside that was delivering at a rate of 2.5 liters per minute.

An interview was conducted with the Administrator at 10:00 am on When asked who managed the for Resident #4, she stated hospice came in once weekly and performed this service. She explained that Resident #4 received continuous and when hospice was not in the facility, she herself would make sure the was running, and the nasal canula was in place. She stated Resident #4 sometimes pulled the canula out. She also stated she had to turn the concentrator on and off.

An interview was conducted with Resident #3 at 10:46 am on She handed this surveyor a sheet of paper that indicated she was to wear hose (compression stockings) daily. The directions for use were "on in the morning and off at bedtime." Resident #3 pointed to the the stockings, which were hanging on her closet door. When asked if she could put them on and take them off on her own, she said "No." She stated Employee A did this for her.

An interview was conducted with Employee A at 11:23 am on She confirmed she had to place the compression hose on for Resident #3 on a daily basis after her shower. She also stated she turned on the concentrator for Resident #4, and made sure the nasal canula was in place, as the resident often removed it.

A personnel file review conducted for Employee A found she was hired in 2014 as a caregiver. Further review found she had no license to provide assistance with or compression stockings.

An interview with the Administrator was conducted at 2:15 pm on She acknowledged that unlicensed staff were not permitted to assist with provision of skilled services for Resident #3 or Resident #4.

3. A personnel file review was conducted for Employee A found she was hired in of 2014. There was no documentation that Employee A received the required training in the facility's policy and procedures for emergencies.

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A personnel file review conducted for Employee B, hired , found no evidence she received the required training in the facility's emergency procedures, incident reporting, or resident rights. In addition, Employee B had no current certification in

An interview was conducted with the Administrator at 1:15 pm on . She confirmed the missing trainings for Employees A and B.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on a review of personnel files, and interview with the Administrator, the facility failed to ensure the required inservice trainings for 2 of 3 sampled employees (Employees A and B).

The findings include:

A personnel file review conducted for Employee A found she was hired in of 2014. There was no documentation that Employee A received the required training in the facility's policy and procedures for emergencies.

A personnel file review conducted for Employee B, hired , found no evidence she received the required training in the facility's emergency procedures, incident reporting, or resident rights. In addition, Employee B had no current certification in

An interview was conducted with the Administrator at 1:15 pm on . She confirmed the missing trainings for Employees A and B.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation and interview with the Administrator, the facility failed to store sufficient supplies of potable water for the census in case of an emergency.

The findings include:

An observation of the emergency potable water supply was conducted at 1:45 pm on . There were approximately 7 gallons of water on hand for the current census of 5 residents.

An interview was conducted at 1:50 pm on . She confirmed there were insufficient supplies of water on hand in the event of the emergency.

Class III

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC
Based on observation and interviews with staff, the facility failed to ensure to a safe living environment by preventing safe egress from the facility in the event of an emergency.

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The findings include:

On arrival to the facility at 9:00 am on . Employee A (a caregiver) responded to the doorbell. She was observed through the front door window to unlock the deadbolt on the door using a key. An observation of the interior of the front door confirmed there was a key-operated deadbolt lock. At the top of the door, a hotel-style latching lock was observed (photos obtained). Employee A removed the key from the lock, and kept it during the survey.

An interview was conducted with Employee A at 9:05 am on . She stated Residents # 1, #3 and #5 were all ambulatory without assistance. When asked if these three residents had access to the front door key in order to exit the home in the event of an emergency, she said "No." Employee A explained that she kept the deadbolt key on her. She was asked how the residents would exit the front door in an emergency if she was not available. She stated she would have to unlock the deadbolt to let them out. Employee A explained that Resident #1 wandered, and the lock was intended to keep her from exiting the facility. She acknowledged that in the absence of her availability, the locks prevented timely egress, and acted as a for Resident #1 by locking her in the home.

An interview was conducted with the Administrator at 2:15 pm on . She acknowledged the locks were not permitted, and confirmed the unsafe nature of the mechanisms.

Class III

0162-Records - Resident 58A-5.024(3) FAC
Based on a review of resident records and interview with the Administrator, the facility failed to obtain weights on a semi-annual basis, or to obtain written consent for unlicensed staff to assist with the self-administration of medication for 1 of 2 sampled residents (Resident #5) whose records were reviewed.

The findings include:

A record review conducted for Resident #5 found she was and had diagnoses including , and . A review of the weight record for this resident found the last weight obtained for her was in of 2014. The resident health assessment dated indicated that Resident #5 required assistance with the self-administration of medications. Further review of the record found no written consent for unlicensed staff to assist with medication self-administration.

An interview was conducted with the Administrator at 12:15 pm on . She reviewed the record and confirmed that a semi-annual weight was overdue for Resident #5. She also confirmed the missing consent for assitance with medications.

Class III

0167-Resident Contracts 58A-5.025 FAC
Based on a review of resident contracts, and interview with the Administrator, the facility failed to ensure the completed resident contracts contained a provision of a 30 day written notice of rate increase for 2 of 2 sampled residents (Resident #3 and #5).

The findings include:

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A record review for Resident #3 found a signed resident contract dated . The contract did not have a written provision that the facility would provide a 30 day written notice prior to a rate increase.

A record review for Resident #5 found a signed resident contract dated . The contract did not have a written provision that the facility would provide a 30 day written notice prior to a rate increase.

An interview and contract review was conducted with the Administrator at 12:15 pm on . She confirmed the missing provision in the contracts for Residents #3 and #5.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Gentle Care Assisted Living, I
66 Blare Castle Drive
Palm Coast, FL 32137

Dear Administrator:

This letter reports the findings of a state biennial licensure 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, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/JM/sm
Enclosure

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