STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967590	**03/13/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
A SECOND HOME OF RIVIERA BEACH INC	**120 WEST 22ND STREET RIVIERA BEACH, FL 33404**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced abbreviated Relicensure survey was conducted on and at A Second Home of Riviera Beach. The facility had deficiencies found at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on observation, record review and interviews, the facility failed to ensure a face to face medical examination by a health care provider was conducted after a significant change in a resident's medical diagnosis/status and that it was reflective of a resident's current care needs, with the results of the examination recorded on AHCA Form 1823 (Health Assessment), for 1 of 2 residents whose records were reviewed (Resident #3).

The findings include:

A record review was conducted for Resident #3. This resident was admitted to the facility on with current diagnoses recorded on AHCA Form 1823, dated of and Chronic It is noted on the Health Assessment that the resident is on Hospice and is non-ambulatory. There is no indication of diet requirement(s) or the type of assistance needed for medications. Activity of Daily Living (ADL) Levels are recorded as follows: Ambulation, Bathing, Dressing, and Transfer all require "assistance". Resident is "independent" with eating, and "needs supervision" for toileting. The Health Assessment also states resident is not "bed ridden".
An interview was conducted with the Hospice [name of the unit] Manager on at 9:23 AM, she states, " Resident went on Hospice on He was doing well. He was ambulatory and we had started discharge planning. Then, he began having episodic changes and began deteriorating. [Resident #4] was not bedbound when he went on Hospice; he was ambulating and going to Adult Day Care. Resident never went off Hospice once he was admitted. We had started discharge planning, but did not complete it. It's hard to tell, but it looks like from the Hospice nurse's notes that he [Resident #4] went bed bound in [2015]. "
The Hospice Team Manager shared the following information gathered from the Hospice Notes. "In 2014, the Patient is awake and oriented X 3, saturation is 93% on there is a small on leg. It was a malignancy removed at office. On the patient is going to the daycare center, he is ambulatory. On the patient is going to the daycare, and he is ambulatory. On Resident is at the daycare center; he is and getting aggravated more easily; his stats are low. He had a For the past 3 months, 75% of his meals were eaten, but on this date he only consumed 10%."
Further interview with the Hospice Team Manager, at this time, revealed the following information from the Hospice notes directly. "It looks like he started to decline in " On there was a functional decline. At daycare, he is more forgetful. On he is rated at at Fast 6E. He is able to voice his needs; he is using continuous he is only able to ambulate 15 feet without needing the patient will only attend daycare part-time because of and fatigue. On he has in his feet, his eyes are sunken; he wakes up but back asleep. PPF score is 7C. He is deteriorating; he is observed lying in bed, low stats 88-85%, he has an external and his abdomen is distended. The patient's diet is changed to pureed in and his appetite is improving. On patient's PPS is 7D. His appetite has increased, but there is a

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continual decline."
The Hospice Team Manager confirms, "Hospice CNA is going 7 days a week, and the Hospice nurse is going 2 times a week; we are watching closely for crisis care, when we place the nurse on round the clock (24 hours). I am not sure if he is on a low air loss mattress, but the mattresses we have are already low pressure mattresses. He has no pressure sores. One person can turn the resident if they know what they're doing."

During interview with Administrator on at 11:40 PM, she confirmed aforementioned and that the resident is bedridden. She stated, "We turn and reposition [the resident] by placing pillows underneath him every 2 hours. One person can turn him." The Administrator confirmed no further assessment had been completed on this resident since his decline and becoming bedridden to ensure the facility could meet the residents current care needs and that the resident met the critieria for continued residency.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review and staff interview, the facility failed to 1) provide adequate and appropriate health care consistent with established and recognized standards within the community related to control regarding assistance with self-administered medications for 2 of 2 residents whose medication assistance was observed (Resident #1 and #2) and 2) ensure physical used by the facility were ordered by the resident's physician and reviewed by the physician annually, for 1 of 3 residents observed (Resident #3).

The findings include:

1a) On at 9:05 AM, Employee A stands next to Resident #1 and removes the resident's pills out of the plastic cup with her bare fingers, which were not washed/sanitized prior to touching the medication, and informs the resident of the name of each of the medications and encourages the resident to swallow the pills. Resident #1 places the pills in his mouth, chews them, and washes them down with the water provided by Employee A.

1b) On at 10:15 AM, Employee A brings Resident #2's medication containers to the Dining The employee informs Resident #2 of each of the medications placed into the small plastic medication cup. However, Employee A used her unsanitized, ungloved finger to remove a single pill from a few of the pill containers and place them into the medication cup.

The Florida Department of Elder Affairs Guide to Providing Assistance with Self-Administered Medications documents staff must wash hands for at least 20 seconds before and after handling medications. This guide also documents staff must wear gloves when touching medications directly.

2) On at 10:45 AM, Resident #3 was observed laying in his bed in his alert, clean and At this time, it was observed that one side of Resident #3's bed was placed against and the other side of

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the Resident's bed had full bed rails, both of which were raised. The mattress appeared to fit the bed appropriately so as not to leave any gaps between bed and rails. The Administrator is advised full bed rails are not allowed, and considered a [redacted] if resident is not able to remove them himself. The Administrator responded, "Even if the resident is on Hospice?" The Administrator is informed that full bed rails are not allowed even if resident is on Hospice.

A review of Resident #3's medical record was conducted; no physician order for 1/2 rails are found within resident's record. A request was made to the Administrator on [redacted] at 11:00 AM for a physician's order for 1/2 rails, but she stated there is no order for bed rails.

During interview with Administrator on [redacted] at 11:40 PM, she explains, "The reason the rails were used is because the resident would get agitated and move around in bed. The rails were on the bed when it came from Hospice. I am in the process of getting a doctor's order for 1/2 rails."

Class III

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

Based on observation and staff interview, facility staff failed to follow specifications of Section 429.256(3) F.S. when assisting resident(s) with self-administration of medications, for 1 of 2 residents whose provision of medications was observed (Resident #1).

The findings include:

On [redacted] at 8:51 AM, a small plastic cup of medications is observed sitting on the dining [redacted] next to Resident #1's water glass. The plastic cup contains Resident #1's morning medications. Resident #1 is seated at the Dining [redacted] eating his breakfast while the two staff members on duty are in another [redacted], not visible from the dining [redacted]. The medications have been left uncovered and unsecured (see photo evidence #2). The resident is not informed of the medications and the dosage that have been provided.

On [redacted] at 9:03 AM, Employee A shows the surveyor another plastic cup in which Resident #1's afternoon medications have already been placed. This cup had been placed on the counter in the kitchen. On [redacted] at 9:10 AM, Employee A brought Resident #1's inhaler to the Dining [redacted] where Resident #1 was seated. Employee A informed the resident of the medication's name and the purpose of the medication; the employee then placed the inhaler into Resident #1's mouth and dispensed the medication.

During interview with Employee A on [redacted] at 10:30 AM, she stated she had just completed a 4 hour a continuing education medication training in [redacted] of 2015. Employee A acknowledged the deficient practices observed during the medication observations for Residents #1 and #2.

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Class III

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

Based on observation and staff interview, the facility failed to keep centrally stored medications in a locked cabinet, cart, or other locked storage receptacle, , or area at all times; kept separately from the medications of other residents, and properly sealed, for 3 of 3 residents whose medications are centrally stored.

The findings include:

1) On at 8:51 AM, a small plastic cup of medications is observed sitting on the dining next to Resident #1's water glass. The plastic cup contains Resident #1's morning medications. Resident #1 is seated at the Dining eating his breakfast while the two staff members on duty are in another , not visible from the dining . The medications have been left uncovered and unsecured (see photo evidence #2). On at 9:03 AM, Employee A shows the surveyor another plastic cup in which Resident #1's afternoon medications have already been placed. This cup had been placed on the counter in the kitchen.

2) On at 9:00 AM, A small table located in the kitchen, place underneath the locked medication cabinet, contains several bottles of medications, both prescribed and over-the-counter, which are in an open, unsecured area (see photo evidence #1)

3) On at 9:15 AM, the medication cabinet which holds residents' medications, and which is equipped with a lock so medications can be secured, is observed open and unattended. Employees A and C are not within sight of the cabinet for 5 minutes (see photo evidence #3).

During interview with the Administrator on at 10:30 AM, she acknowledged the deficient practice found and secured all medications immediately.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, resident record review and staff interview, the facility failed to follow physician's orders for the proper timing of residents' medications, for 2 of 2 residents whose medications were reviewed (Residents #1 and #2).

The findings include:

1) On at 8:51 AM, Resident #1 is observed eating breakfast. Next to his plate is the resident's medication

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cup containing (20 mg) and (0.25 mcg).
The physician's orders for these medications are as follows: 20 mg, each morning before eating for stomach , and 0.25 mcg, each morning before eating for .

2) On at 10:15 AM, Resident #2 is given her (75 mcg) with her breakfast. The physician orders for this medication is as follows: 75 mcg, each day on empty stomach.

When interviewed, Employee A stated she was unaware the medication was to be given on an empty stomach before breakfast.

Class III

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and staff interview, the facility failed to properly label over-the-counter (OTC) medications, for 1 of 2 residents observed during assistance with self-administered medications (Resident #2).

The findings include:

During medication assistance observation for Resident #2 at 10:15 on , the Resident was given OTC supplements (Iron, with DHA, D3, and with D3) from bottles which had not been labeled with the resident's name.

On at 10:30 AM, the Administrator acknowledges the lack of labeling on the over-the-counter supplements.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and review of facility menu, the facility failed to follow the planned and approved menu, or make appropriate substitutions with items of comparable nutritional value, for 3 of 3 residents who eat meals at the facility.

The findings include:

On at 8:40 AM, Resident #1 is served breakfast which consists of hashbrowns, fresh fruit, sausage patty and beverage of choice (coffee). On at 10:15 AM, Resident #2 is also served hashbrowns, fresh fruit, sausage patty and beverage of choice. During an interview with Administrator on at 10:30 AM , she reveals Resident #3 was served the same breakfast in his as the resident is unable to come to the table to eat.

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A review of the posted Menu for date of survey shows the following foods were to be served for breakfast: 4 oz fruit, 1 Banana, 4 oz Hot/ cereal, 2 oz scrambled eggs, 2 slices of Toast with Margarine, 2 tsp. jelly, 8 oz. milk, and 6 oz. coffee.
There are no substitutions noted for this meal.

The Administrator was interviewed on at 10:32 AM regarding the approved dietary menu. She acknowledged that the breakfast served did not follow the approved dietary menu, and substitutions had not been noted prior to, or at the time of, the meal served.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on employee record review and staff interview, the facility failed to maintain personnel records for each staff member containing a copy of employment application with references furnished, for 1 of 3 employee records reviewed (Employee C).

The findings include:

During employee record review on , no completed employment application containing personal references for Employee C, Certified Nursing Assistant/Housekeeper (hire date , could be found within this employees personnel file.

A request for a copy of the employment application was made to the Administrator on at 11:30 AM, but Administrator stated she did not have an employment application for Employee C at this time.

Class III

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

Based on employee record review and staff interview, the facility failed to ensure all staff members were in compliance with the Level II background screening requirements, for 1 of 3 employees (Employee A/Administrator). As evidence of the facility failure to ensure Employee A completed a new screening after five years.

The findings include:

On during record review for Administrator (hire date , it was discovered that her current background screening had expired on . A new screening had not been conducted since expiration. Review of the Agency's background screening website revealed a new screening is required for Employee A, "A new Screening is Required".

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During interview conducted with the Administrator on at 11:30 AM, she stated, "I didn't know I had to get another background screening; I thought all I had to do was sign another Affidavit of Compliance, which I did on . It is located in my file." It was explained to the Administrator that all Level II background screenings expire after 5 years. A new screening must be conducted before expiration to be in compliance with state requirements.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
A Second Home Of Riviera Beach Inc
120 West 22nd Street
Riviera Beach, FL 33404

Dear Administrator:

This letter reports the findings of a State Relicensure Survey that was conducted on 26, 2015 and 2015 by a representative from 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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