STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911325	**03/11/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HPLS ASSISTED LIVING INC	**300 EAST KALEY AVENUE ORLANDO, FL 32806**	

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

0000 - Initial Comments

Complaint investigation #2014012238 conducted from to . HPLS had deficiencies found at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview the facility failed to ensure that 3 of 8 sampled resident's record (#5, #6, and #7) contained a completed health assessment that addressed all the required criteria.
Findings:
1. Resident record review for resident #5 revealed a health assessment report AHCA form 1823 dated 11 . Continued review revealed the assessment did not indicate if the resident needed help with medications. That portion of the form was blank.
2. Resident record review for resident #6 revealed a health assessment report 1823 dated that indicated the resident was a danger to self " tends to falling - do things himself". The assessment did not indicate whether or not the resident was free from communicable . That portion of the form was blank.
3. Resident record review for resident #7 revealed a health assessment AHCA form 1823 dated . Continued review revealed the assessment did not indicate if the resident needed help with her medications. That portion of the form was blank.
In an interview with the administrator on at approximately 3:30 PM, who stated the information on the assessments was overlooked.
Class III

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

Based on observations, record review and interview the facility retained 1 of 8 sampled residents (#1) who exceeded residency criteria in assisted living facility (ALF) as she was unable to transfer and needed total assistance with activities of daily living; and failed to obtain a new health assessment when 2 of 8 sampled residents (#2 and 6) were admitted to hospice; and failed to take in consideration the accuracy of the on the Health Assessment Form-AHCA 1823 for 1 of 8 sampled residents and retained a resident who exceeded ALF residency criteria.
Findings:
Observations during the facility tour on at approximately 9:15 AM noted resident #1 was in her bed. She was in a hospital bed with half-bed rails and on. She was
Observations on at approximately 1:15 PM noted resident #1 still in bed. She was fed by staff. She remained in bed.
Observations on at approximately 9:30 AM noted resident #1 was in her bed. She was in a hospital bed with half-bed rails and on.
Observations on at approximately 1 PM noted resident #1 still in bed. She was fed by staff. She remained in bed.
Observations on at approximately 3:30 PM noted that staff C and E provided personal care to resident #1

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while she was in the bed. The 2 staff turned her, cleaned her and repositioned her. The resident did not assist with her toileting or repositioning.
In an interview on at approximately 3:30 PM with staff #C who stated resident #1 "is total care She doesn't walk we do everything for her".
In an interview on at approximately 3:30 PM with staff #E who also stated resident #1 "is total care. She doesn't walk we have to do everything for her".
Observations on at approximately 3:30 PM noted staff #E staff put on the to the resident after toileting was done in the bed.
Resident record review that included weights revealed a health assessment dated that indicated the resident needed assistance with all her activities of daily living. She had diagnoses of high difficulty swallowing accident acute kidney failure, and left lower The report indicated she was a "feeder". A puree diet was ordered. Continued review revealed a weight record sheet that indicated a weight of 95 pounds on On 11/1/4 and the log indicated "unable to weigh, unable to stand or sit independently.
2. Record review for resident #2 revealed she was admitted to hospice on Continued review revealed an updated health assessment dated A health assessment conducted when the resident exhibited a significant change, that required admission to hospice was not available.
3. Record review for resident #6 revealed an admission health assessment report 1823 dated Continued review revealed an updated health assessment dated He was admitted to hospice on A health assessment that was conducted when the resident exhibited a significant change that required admission to hospice was not available.
4. Record review for resident #3 revealed an admission health assessment report 1823 dated that listed diagnoses of and According to the health assessment resident was bed/chair bound.
Observations on at approximately 10 AM noted the resident ambulated independently in the community.
In an interview with the administrator on at approximately 3 PM who stated resident #1 did not spend the entire day in bed, she was transferred to the wheelchair. She confirmed the resident was unable to perform activities of daily living even with assistance. She was not aware that once admitted to hospice a revised health assessment was needed. She explained when resident #3 moved in; he was in a wheel chair and on hospice. He has health has now improved and he is no longer on hospice and ambulates independently.
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 for 2 of 8 sampled residents (#2 and #6) and with a healthcare provider's order.
Findings:
During the facility tour on at approximately 9: 30 AM the administrator identified resident #2 as receiving hospice care. Resident #6 was also under the care of hospice.
1. Observations at approximately 9:30 AM of the bed of resident #2 noted it had half-bed rails in place. The

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0030 Continued From page 2

resident sat in the living was
Record review for resident #2 revealed she was admitted to hospice on . Continued review revealed the healthcare provider's order for the use of half-bed rails was dated . Continued review revealed there was not an updated healthcare provider's order (due for the use of the half-bed rails wan not available.
2. Observation of resident #6's bed revealed 1 full rail on the right side of his bed. The left side of the bed was against the wall. He was alert and oriented.
Record review for resident #6 revealed a healthcare provider's order dated that indicated half-bed rails for assistance. Continued review revealed no evidence to confirm that a revised order was obtained for 2014.
In an interview with the administrator on at approximately 3:30 PM who stated the hospital bed was delivered with the full rails and the orders for the half-bed rails were overlooked.
Class III

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

Based on observations and interviews the facility failed to ensure when a staff assisted with self -administration of medications she observed the 1 of 8 sampled residents (#3) take the medication.
Findings:
During the facility tour on at approximately 9:15 AM, the administrator asked resident #3 if he had taken his treatment. He replied "Not yet".
Observations during the medication pass on at approximately 11:30 AM noted that the administrator poured the medication solution one vial every 6 hours as needed for in the chamber and told resident "You can take the treatment now or after lunch. He replied after lunch".
In an interview with the administrator on at approximately 3:30 PM who stated she thought it was OK for the resident who was alert to decide when he wanted the medication.
Class III

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

Based on observations and interview the facility failed to ensure medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, or area at all times, out of sight of all residents.
Findings:
Observations on at approximately 3:00 PM noted on top of the dresser in the resident #3 there was a box of 05 mg/ml with a prescription label dated that indicated one twice daily and a box of inhalation with a prescription label dated that indicated one every 6 hours as needed for
In an interview with the resident on at approximately 1 PM, who stated he did not lock the door when he left the
Class III

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0078 Continued From page 3

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

Based on observations, record review and interviews 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 (#E) to apply , failed to ensure that freedom from was documented yearly for 1 of 5 sampled staff (#D).
Findings:
Observations during the facility tour on at approximately 9:15 AM noted resident #1 was in her bed. She was in a hospital bed with half-bed rails and on. She was
Observations on at approximately 3:30 PM noted that staff #C and #E provided personal care to resident #1 while she was in the bed. The 2 staff turned her, cleaned her and repositioned her. The resident did not assist with her toileting or repositioning.
1. Observations on at approximately 3:30 PM noted staff #E staff put on the to the resident after toileting was done in the bed.
Resident record review that included weights revealed a health assessment dated that indicated the resident needed assistance with all her activities of daily living. She had diagnoses of high , difficulty swallowing accident acute kidney failure, and left lower The report indicated she was a "feeder". A puree diet was ordered. Continued review revealed a weight record sheet that indicated a weight of 95 pounds on On 11/1/4 and the log indicated "unable to weigh, unable to stand or sit independently. A healthcare provider's order dated indicated at 4 litter per minute by nasal cannula.
Personnel record review for staff #E revealed she was hired on and was not nurse, therefore not licensed to apply

2. Personnel record review for staff D revealed she was hired sometime in 2014, exact date not clear. Continued review revealed a health care provider statement dated that indicated freedom from communicable including Continued review revealed no evidence to confirm she was free from yearly thereafter, due
In an interview with the administrator on at approximately 3 PM who stated resident #1 did not spend the entire day in bed, she was transferred to the wheelchair. She confirmed the resident was unable to perform activities of daily living even with assistance. She also confirm staff #D needed a test.
Class III

0082 - Training - - 58A-5.0191(3) FAC

Based on personnel record review and interview the facility failed to ensure 1 of 5 sampled staff (# E) attended a one- time training regarding
Findings:
Personnel record review on for staff #E, hired 2015 revealed no evidence to confirm that he had attended a one- time training regarding
In an interview with the administrator on at approximately 3:30 PM, who stated the staff had the training but

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she did not have a certificate available.
Class III

0083 - Training - First Aid and [redacted] - 58A-5.0191(4) FAC

Based on record review and interview the facility failed to ensure a staff member who had completed courses in First Aid and [redacted] and held a currently valid card documenting completion of such courses was in the facility at all times (E and B).
Findings:
1. Staff schedule review revealed that staff #E was the sole caregiver on [redacted] and 3/9 during the 3 PM to 11 PM shifts and on [redacted] and [redacted] during the 11 PM to 7 AM shifts.
Staff schedule review revealed that staff #B was the sole caregiver on [redacted] and [redacted] during the 7 AM to 3 PM shifts, on [redacted] and [redacted] during the 3-11 shifts and on [redacted] during the 11 PM to 7 AM shift.
Personnel record review staff #E revealed she was hired [redacted] 2015 and was not a nurse. Continued review revealed a First Aid and [redacted] training certificate dated [redacted] and valid through [redacted]. Continued review revealed the training was done on line (Internet) by the America Academy of [redacted] & First Aid. The course was not offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American [redacted] Association, or National Safety Council; or a provider approved by the Department of Health.
2. Personnel record review staff #B revealed she was not nurse. Continued review revealed a First Aid certificate that expired on [redacted]. Continued review revealed no evidence to confirm she had current First Aid certification.
In an interview with the administrator on [redacted] at approximately 3:30 PM who stated she thought that the Internet training was acceptable. She did realize the First Aid training for staff #B had expired.
Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on record review and interviews the facility failed to ensure 1 of 4 unlicensed staff (#D) who provided assistance with self-administered medications completed a 4 hour class prior to assuming the responsibly.
Findings:
Personnel record review for staff #D revealed she was hired in 2014. A certificate dated [redacted] indicated that a 2 hour medication training update was received. Continued review revealed an APD validation certificate dated [redacted] regarding medication administration. Continued review revealed no evidence to confirm she attended a 4 hour class regarding the provision of assistance with self-administration of medication in an assisted living facility prior to assuming that responsibility.
In an interview with the administrator on [redacted] at approximately 3:30 PM, who stated the staff assisted the residents with self -administration of medications and she thought that training met the requirement.
Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

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0091 Continued From page 5

Based on personnel records review and interview the facility failed to ensure that personnel records contained certificates, or copies of certificates, of any training required by this rule was documented in the facility's personnel files for 1 of 5 sampled staff (#E).
Findings:
In an interview with staff #E on [redacted] at approximately 3:30 PM, who stated she provided assistance with self-administration of medications to the facility residents.
Personnel record review on [redacted] for staff #E revealed she was hired in [redacted] 2015 and was not a nurse.
Continued record review a test regarding the provision assistance with self- administration of medications. The test was dated [redacted] Continued review revealed no evidence to confirm that a certificate that indicated:
1. The title of the training program;
2. The subject matter of the training program;
3. The training program agenda;
4. The number of hours of the training program;
5. The trainee's name, dates of participation, and location of the training program;
6. The training provider's name, dated signature and credentials, and professional license number, if applicable.
In an interview with the administrator on [redacted] at approximately 3:30 PM, who stated the staff was trained, she overlooked the certificate.
Class III

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

Based on observations and interview the facility failed to ensure to the planned menu was conspicuously posted or easily available to residents and failed to ensure the all the foods listed on the menu were served.
Findings:
Observations during the facility tour on [redacted] at approximately 9:15 AM noted the menu was not posted by the resident's common areas.
The menu to be served on [redacted] was curried chicken, rice, mixed veggies, apple pie & ice tea/lemonade. The menu was not served, instead meat loaf, carrots, yellow rice, yellow cake, ice tea/lemonade were to be served.
In an interview on [redacted] at approximately 11:30 AM with the administrator who stated the menu was kept in the kitchen and the residents did not have access to the kitchen.
Observations of the lunch meal at approximately 12 PM noted that the residents were not offered desert. The yellow cake was not served.
In an interview with the administrator on [redacted] at approximately 12:30 PM, who stated the menu was changed to give a break from the monotony of the same foods. The desert was not served because the residents most likely would not eat it; they would have cake for a snack.
At approximately 2 PM staff was observed to serve residents cake in a small cup and a drink.
Class III

0162 - Records - Resident - 58A-5.024(3) FAC

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0162 Continued From page 6

Based on observations, record review and interview the facility failed to ensure that 2 of 2 sampled resident records (#2, #6 and #7) contained all the required components.
Findings:
1. In an interview with the administrator on at approximately 11:30 AM she stated resident #2 took her medications crushed.
Record review for resident #2 revealed she was admitted to hospice on Continued review revealed no evidence to confirm that a healthcare provider's order to crush the resident's medications had been obtained.
2. Resident #6 was identified as being under the care of hospice. Resident record review revealed a hospice assessment dated that indicated he was on at 4 liters per minute via nasal cannula. Continued review revealed a health care provider order for the was not available for review.
3. Resident record review for resident #7 revealed a health assessment report AHCA form 1823 was dated The review revealed the assessment did not indicate if the resident needed help with her medications. That portion of the form was blank. Continued record review that included the Medication Observation Record (MOR) revealed she received assistance with self -administration of medications from the facility's unlicensed staff. The informed consent regarding assistance with self-administration of medication was dated , but did not indicate whether or not the staff who provided the assistance would or not be supervised by a licensed nurse.
In an interview with the administrator on at approximately 3 PM who stated the documentation was overlooked.
Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on observations, interviews and record reviews the facility failed to ensure that complete nursing progress notes per 58A-5.0131 F.A.C. and nursing assessments were maintained for 1 resident (1) in a sample of 8, who received limited nursing services (LNS).
Findings:
In an interview with the administrator on at approximately 9 AM who stated there were no residents who received LNS.
Observations during the facility tour on at approximately 9:15 AM noted resident #1 was in her bed. She was in a hospital bed with half-bed rails and on. She was
Observations on at approximately 3:30 PM noted that staff #C and #E provided personal care to resident #1 while she was in the bed. The 2 staff turned her, cleaned her and repositioned her. The resident did not assist with her toileting or repositioning.
Observations on at approximately 3:30 PM noted staff #E staff put on the to the resident after toileting was done in the bed.
Resident record review that included weights revealed a health assessment dated that indicated the resident needed assistance with all her activities of daily living. She had diagnoses of high , difficulty swallowing accident acute kidney failure, and left lower The report indicated she was a "feeder". A puree diet was ordered. A healthcare provider's order dated indicated at 4 liters per minute by nasal cannula. Continued review revealed

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N278 Continued From page 7

no evidence to confirm nursing progress notes were maintained each time the service was provided and that monthly nursing assessment were conducted.
In an interview on at approximately 3 PM with the administrator, a Registered Nurse, who stated she assisted the resident with the but did not know that was a Limited Nursing Service.
Class III

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

Based on personnel record review and interview the facility failed to ensure 1 of 5 staff (#E), whom was in a role that required a background screening, did not have any disqualifying offenses and allowed staff #E to work before the screening was completed.
Findings:
Observations on at approximately 3:30 PM noted that staff #C and 3E provided personal care to resident #1 while she was on the bed. The 2 staff turned her, cleaned her and repositioned her. Continued observations noted staff #E staff put on the to the resident after toileting was done in the bed.
Personnel record review on for staff #E revealed she was hired in 2015 and was not a nurse.
Continued record review revealed background screening results dated that indicated she was not eligible to work in an AHCA licensed facility. The report was printed at 11 AM. On at approximately 3 PM the Agency background screening website indicated the same results.
Review of the facility's staff schedule for and 2015 revealed staff #E was scheduled to work different shifts that included 7 AM to 3 PM, 3 PM to 11 PM and 11 PM to 7 AM.
In an interview on at approximately 4 PM with the owner /administrator, who stated she was surprised the staff was not eligible, but he failed to review the results before he allowed the staff to work.
Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Hpls Assisted Living Inc
300 East Kaley Avenue
Orlando, FL 32806

RE: CCR #2014012238 w/LNS

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on 11, 2015 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,

Teresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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