STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922141	R **03/11/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
RENAISSANCE RETIREMENT CENTER	**300 WEST AIRPORT BLVD. SANFORD, FL 32771**	

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

0000 - Initial Comments

Second revisit to Complaint Investigation #2014004285 in conjunction with the revisit for Complaint Investigation #2014007505 and Complaint Investigation #2014010408 were conducted on . . . . . Renaissance Retirement Center Assisted Living Facility had deficiencies found at the time of the visit.

0025 - Resident Care - Supervision - 58A-5.0182(1) FAC

A025 remains uncorrected.

Based on record review and interview, the facility failed to maintain a written record that the family and health care provider were contacted of significant changes and or illnesses which resulted in a hospital admission for 1 of 7 sampled residents (#3), and failed to offer personal supervision, as appropriate for residents which included general awareness of the resident's whereabouts and allowed 1 of 7 sampled residents to elope from the facility after she was identified as an elopement risk (#1).

Findings:

1. During an interview with the Resident Care Coordinator on , at approximately 12 PM, she stated resident #3 was admitted into the hospital on . . . . . but did not know why.

Record review for resident #3 did not reveal any documentation as to what had transpired that caused the resident to be admitted into the hospital. Further record review revealed there was no documentation to confirm that the family and health care provider were contacted to inform them of the hospital admission.

During an interview with the Resident Care Coordinator on . . . . . at approximately 3 PM, she stated documentation regarding the hospital admission and notification to the resident's family and health care provider were not in the resident's record.

2. Record review for resident #1 revealed that she was admitted to the facility on . . . . . Resident #1's Elopement Risk Evaluation Form was undated but signed by a nurse. The resident was assessed to be an elopement risk. Review of the resident's Health Assessment (1823) dated . . . . . listed under or behavioral status, . . . (patient) has . . . . . Special precautions read, . . . sundowns at night." The physician also checked for the resident to be observed daily.
Review of the observation log for resident #1 revealed the following:
Resident moved in . . . . . at 4 PM.
From . . . . . until , it is documented that the facility did "2 hour checks" on the resident.
On "Resident is very . . . . . and keeps stating she's going to leave the facility. As of 10 PM she is refusing to go to bed or into her . . . . . Please check on her every hour because of elopement risk."
From . . . . . to , two hour checks were done.

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0025 Continued From page 1

From to , the resident was on 2 hour checks according to the observation log.
On at 6:30 AM, two hour checks were done; resident continues to wander, looking for the exit.
On at 9 AM, the resident was observed in the increased and increased . The resdient denied pain at this time. The resident was placed on 1 hour checks; staff were to continue to monitor.
On , the resident eloped; the family and primary care physician were notified.
Further review of resident #1's record revealed documentation of interventions that were put place to keep the resident safe once the facility became aware the resident was at risk for elopement.

During an interview on at approximately 3:40 PM with staff A, a medication technician, she stated she was assigned to watch the resident during her shift, 3 to 11 PM on . Staff A stated she was aware that the resident was an elopement risk. According to staff A, she took resident #1 outside by the smokers. She explained that the resident did not smoke but enjoyed being outside. Staff A stated at 5 PM on , she took resident #1 to the resdient's it was time for her to conduct a medication pass. Staff A stated she conducted medication pass from 5 PM to 6 PM. According to staff A, when she went downstairs, the police was there with resident #1 in the back seat. At that time, the family was called. Staff A had no explanation for the time when she finished the medication pass at 6 PM until the resident was brought by to the facility by Law Enforcement at 8:25 PM.

The Adverse Incident report, dated , indicated the resident was brought back by police and the facility sent her to the hospital. It also indicated that the case manager at the hospital will find placement in a memory care unit since the resident is not appropriate to come back to the facility.

Review of the Police Department Dispatch Record revealed on the Police Department was contacted by an unknown person at 8:03 PM on and reported a white female was walking toward Live Oak Blvd. At 8:09 PM on , it was reported the subject just passed the far west entrance of Village Lakes. At 8:25 PM on , the white female was returned to the facility and turned over to staff.

Resident #1 was left unsupervised for approximately two and half hours. The facility was not aware the resident had left the facility until the police returned her to the facility at 8:25 PM on . According to police report, the resident was found on a busy four lane highway.

In an interview with the administrator at approximately 2 PM on , he stated he was not employed at the time of the incident, but knew resident #1 went to the local hospital and was discharged to a skilled nursing facility. At the time of the survey, there was no documentation of disciplinary action or any training or retraining of staff taking care of residents assessed to be an elopement risk.

Class II

0054 - Medication - Records - 58A-5.0185(5) FAC

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

0054 Continued From page 2

A054 remains uncorrected.

Based on record review and interview, the facility failed to ensure accurate Medication Observation Records (MORs) and ..... Sign Out sheets were maintained for 2 of 7 sampled residents (#9 & 15).

Findings:

1. Review of the ..... Sign Out sheets for resident #15 revealed that for 5 milligrams (mg.) 1 twice daily for ' revealed there was a blank space on the sheet that required the signature of the staff who gave the resident his medication and date that the medication was provided. The ..... Sign sheet next to the blank spaces the time 8:15 (AM/PM was not noted). The next space was dated ..... and noted 6:41 (AM/PM was not noted).

Further review revealed there was another ..... Sign out Sheet that noted 5 mg. take 1 tablet twice daily; take 1 tablet by mouth twice daily as needed for . On , the time of the medication noted 7:42 (AM/PM was not noted), on ..... the time noted 8:05 and 7:42 (AM/PM was not noted). On , the time noted 6:20 (AM/PM was not noted). There was another pill given on ..... and the space for the time the medication was given was blank.

2. On a record review of the ..... Log for resident #9 revealed the following prescribed ..... 5-325, 1 tablet by mouth four times daily and 5 mg. tablet, take 3 half tablets 7.5 mg. by mouth three times daily.

Further review of the ..... Log for resident #9 revealed that staff signed the log between ..... and ..... but there was no date or time of day the medication was given to the resident. The ..... Log did not have a staff signature on ..... and a time was not written on the log. After , staff provided this medication to the resident but the ..... Log record did not reveal a date or time as to when the resident received the medication.

A review of the medication observation record (MOR) for resident #9 revealed that all medication prescribed was given and no medicine was missed.

During an interview with the Resident Care Coordinator on ..... at approximately 4 PM, she confirmed that the ..... Log sheet was not up to date.

Class III

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

A 056 remains uncorrected.

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SUMMARY STATEMENT OF DEFICIENCIES
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0056 Continued From page 3

Based on medication observation record (MOR) review and interview, the facility did not make every reasonable effort to ensure that prescriptions were filled or refilled in a timely manner for 2 of 7 sampled residents who received assistance with self-administration of medications (#2 & 15).

Findings:

During an interview with resident #15 on at approximately 12:15 PM, he stated the facility was out of his (HCTZ), a medication, for 2 days.

Review of the MOR for noted that the resident did not have 0.3% eye drops as follows:
at 8:46 AM, the MOR noted pharmacy was notified; awaiting delivery from pharmacy
at 5:57 PM, the MOR noted awaiting refill prescription from the physician.
at 8:19 AM, the MOR noted pharmacy was notified; awaiting delivery from the pharmacy
at 6:13 PM, the MOR noted pharmacy was notified, awaiting delivery from the pharmacy
at 8:07 AM, the MOR noted the resident refused medication at that time.
at 6:06 PM, the MOR noted pharmacy notified, awaiting delivery from the pharmacy.
at 1:56 PM, the MOR noted awaiting refill prescription from the physician.
at 5:10 PM, the MOR noted awaiting an order for clarification from the physician.

The MOR for 2015 noted at 8:19 AM and at 8:09 AM 25 milligrams (mg.) tab; pharmacy notified; awaiting delivery from the pharmacy.

Record review for resident #15 did not reveal any documentation that the facility staff had made a reasonable effort to ensure that the resident's medication was refilled in a timely manner. Resident #15 did not receive his high medication for 2 days.

During an interview with the Resident Care Coordinator on at 3 PM, she stated they were aware that there were still issues with the medications being refilled timely and were working on them.

2. Resident #2's record review revealed that the resident was prescribed 25 mg. tablets, 1 tablet by mouth twice daily and 500 mg. 1 capsule by month three time daily times 7 days.

The record revealed that the facility ran out of 25 mg. tablets. The MORs indicated that on , the resident did not receive his medication because the facility was awaiting a refill order from the physician.

Further review revealed that on , the resident did not receive 500 mg. The MORs showed that the pharmacy notified and the facility was awaiting delivery from the pharmacy.

Review of the resident's chart revealed did not reveal any documentation to indicate the facility made any effort to

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

0056 Continued From page 4

ensure the resident's medication was filled in timely manner.

In an interview with administrator at approximately 2 PM on , he confirmed the findings.

Class II

0163 - Records - Resident, Penalties for Alteration - 429.49 FS

A163 remains uncorrected.

Based on record review and interview, the facility failed to ensure staff did not falsify Medication Observation Records (MORs) for 1 of 7 sampled residents (#3).

Findings:

During an interview with the Resident Care Coordinator on at approximately 12 PM, she stated resident #3 was admitted to the hospital on but did not know why.

Review of the medication observation records (MORs) for 2015 and 2015 for resident #3 revealed that some of his medications were marked as given when the resident was not at the facility as follows:
81 milligrams (mg.) one daily in the morning was marked as given on and at 7 AM.
Biscadyl 5 mg. take 2 tablets (10 mg.) at bedtime was marked as given at 7 PM on
20 mg. once a day was marked as given at 8 AM on and
Glipizde 2.5 mg. one every other day was marked as given at 8 AM on
300 mg. daily was marked as given at 7 AM on and
25 mg. give 12.5 mg. daily was marked as given at 8 AM on and
25 mg. daily was marked as given at 8 AM on and
0.4 mg. 2 capsules once daily at 7 PM was marked as given on at 7 PM.

During an interview with the Resident Care Coordinator on at approximately 3:45 PM, she confirmed that the resident was in the hospital at the times of these documented medication administrations found in the resident's record.

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

Administrator
Renaissance Retirement Center
300 West Airport Blvd.
Sanford, FL 32771

RE: 2nd revisit to CCR#2014004285

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on . . 11, 2015 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than . . 2015.**

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 (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Renaissance Retirement Center
300 West Airport Blvd.
Sanford, FL 32771
Attn: Brenda Jarmer

Dear . Jarmer:

This letter reports the findings of a revisit inspection survey conducted on , by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) **by** .

The revisit inspection resulted in findings of non-compliance in the following areas:

1) A0025 - Resident Care - Supervision Class II
The Assisted Living facility failed to maintain a written record of significant changes, and illnesses's which resulted in a hospital admission and failed to offer personal supervision, as appropriate for residents which included general awareness of the resident's whereabouts.

2) A0056 - Medication - Labeling And Orders Class II
The Assisted Living facility did not make every reasonable effort to ensure that prescriptions were filled or refilled in a timely manner for residents who received assistance with self-administration of medication.

3) A0163 - Records - Resident, Penalties For Alteration Class II
The Assisted Living facility failed to ensure staff did not falsify Medication Observation Records (MOR).

Directed Corrective Actions:

Your facility must comply with the following:

1. All employees must be retrained on the facility's elopement response policy and procedures and emergency procedures including chain of command **by** .

2. Your staff need to be trained to know that when they are assigned to watch a resident and provide one on one supervision they are to remain with that resident unless they are relieved by another staff. Staff must be retrained on elopement procedures and this

must be documented and have sign in sheets for Agency review **by** .

3. Your staff must be trained on who needs to be notified if a resident has a change in condition and has a hospital admission as a result. There should be a written record of all significant changes. This training must be conducted **by** .

4. Your staff need to be trained on you policy and procedures for prescriptions to filled and refilled in a timely manner. This training must be conducted by a registered nurse or registered pharmacist. Documentation of this training and sign in sheets must be available for Agency review **by** .

5. Your facility must trained staff on the appropriate way to document on the back MOR's if a resident is in the hospital. Your training should include the importance of keeping accurate documentation of when a resident receives their medications. This training must be conducted by a registered nurse or registered pharmacist. Documentation of this training and sign in sheets must be available for Agency review **by** .

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Lorraine Henry, ALF Unit Orlando, at (407) 420-12534.

Sincerely,

Theresa DeCanio
Field Office Manager

D7JR