STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968166	**06/26/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
PARADISE RETREAT ASSISTED LIVING FACILITY LLC	**5626 SOUTEL DR JACKSONVILLE, FL 32219**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2015003782, was conducted on
Paradise Retreat Assisted Living Facility had deficiencies found at the time of the visit.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview with administrator, the facility failed to failed to provide a therapeutic diet for 1 of 3 sampled residents (Resident #2). In addition, the facility failed to obtain a signed consent for unlicensed staff assisting with self-administration of medication for 2 of 3 sampled records reviewed. (Resident #1, #2)

The findings include:

1) Resident #2 ' s Resident Health Assessment (1823) dated revealed she has a diagnosis of and requires assistance with self- administration of medication. Her diet was recorded as requiring a diet.

On a record review of Resident #2 ' s Medication Observation Record (MOR) revealed that she received The MOR listed 50 units in the morning and 45 units in the pm. The MOR reflected that this dosage was changed from 45 units and 30 units respectively, on per the Advanced Registered Nurse Practitioner (ARNP). The MOR also listed 10 units three times a day; morning, noon and evening.

A review of Resident #2 ' s log revealed that sugars were being monitored daily at 8am and 8pm. Further review found several dates in 2015, where Resident #2 ' s sugars (BS) were running high. On at 8PM, Resident #2 ' s BS was 320; BS was 371; BS was 300; BS was 232; BS was 262; and on BS was 300.

On at 9:38 AM, an observation of breakfast revealed that pancakes were served to all residents. Employee A then served coffee and water. There was nothing else served with the meal. Regular maple syrup was observed being served to all residents at breakfast.

On at 10:20 am, an interview with Employee A was conducted. She stated the menus she was working on for this week was the 3rd week menu. She reported that the breakfast for today was scrambled eggs, sausage, milk, toast, and beverages. She said " (The dietician) did not put the pancakes on the menu, so I try to serve it once a week ". She reported that the facility does not have any residents who require a special diets.

On at 11:55 am an interview with the administrator confirmed that the facility does not offer special diets to anyone.

On at 1:25 pm an interview was conducted with the ARNP. She reported that Resident #2 ' s prescribed diet was an American Association (ADA) diet that was sugar free with lower carbs. She said she

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was not aware the facility did not have a diet menu. She confirmed she had been adjusting Resident #2 ' s due to high sugar readings.

2) A review of Resident #1 ' s record revealed an unsigned notification to allow unlicensed staff to assist with administering medication. (Photographic evidence)
A review of Resident #2 ' s record revealed there was no notification to allow unlicensed staff to assist with administering medication.
On at 4:55 pm the administrator confirmed the findings.
Class II

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

Based on observation, record review and interview with staff, the facility failed to provide assistance with self-administration of medications according to physician ' s order, from an appropriately labeled container, and that precluded independent judgement with for 2 of 3 sampled residents, (Resident #2, #3)

The findings include:

1)
Resident #2 ' s Resident Health Assessment (1823) dated revealed she has a diagnosis of and requires assistance with self- administration of medication. Her diet was recorded as requiring a diet.
On a record review of Resident #2 ' s Medication Observation Record (MOR) revealed that she received The MOR listed 50 units in the morning and 45 units in the pm. The MOR reflected that this dosage was changed from 45 units and 30 units respectively, on per the Advanced Registered Nurse Practitioner (ARNP). The MOR also listed 10 units three times a day; morning, noon and evening. No orders were observed for parameters.
A review of Resident #2 ' s log revealed that sugars were being monitored daily at 8am and 8pm. Further inspection revealed that on , 2015, Resident #2 ' s sugar was only recorded at 8 am. On 22, 23 ,24, and the morning of the sugars were not recorded. On 13, 14 & 15, the log recorded that Resident #2 received 45 units of . The sugar level was recorded on , 2015 as 226 at 8 PM and 300 at 8PM on . 2015.

On at 10:50 am, an observation of in the refrigerator for Resident #2 revealed 2 bags with prefilled syringes, filled with a clear fluid. Each bag had Resident #2 ' s name on it. One of the bags had 24 prefilled syringes of 50 units of an unknown substance in it. There were no syringes with 45 units, which was her evening dose. The second bag had 26 prefilled syringes of 11 units with an unknown clear substance. There were none that had 10 units, which was the ordered dose. (Photographic evidence)

On at 10:20 am an interview with Employee A, a Certified Nursing Assistant (CNA), was conducted.

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SUMMARY STATEMENT OF DEFICIENCIES
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Employee A stated that Resident #2 ' s medication changed on . She stated that if Resident #2 ' s sugar reading is less than 100, Resident #2 doesn ' t have to take her . When asked to clarify, Employee A reported that Resident #2 will not take her or the when her sugar is low, below 100. When asked about the MOR, and the being signed off as given daily, she reported that the correct documentation was on the record. She reported that the MOR was signed incorrectly.

On at 10:59 am, an interview with Resident #2 was conducted. She stated that whoever is working, will hand her the prefilled . She reported that whoever is working, will also check her sugar. She stated that she was unable to draw up her own . She said both Employee A & Employee B have drawn up her .
On at 11:00 am a follow up interview was conducted with Employee A. She stated that Resident #2 does not draw her own . She reported that she had been prefilling syringes and said that Resident #2 was not able to draw up the herself.
On at 11:25 am, an observation was made of Resident #2 checking her sugar. Her sugar read 433.
On at 11:33 am, Employee B, a resident assistant, removed the vial of Resident #2 ' s from the refrigerator. She stated she will have to draw Resident #2 ' s 10 units. As Employee B was about to draw the , she was asked "Are you allowed to draw up her " She said, "Well what am I supposed to do? " Employee B had to be asked to stop proceeding with the for Resident #2. Employee B then asked Resident #2 to come out of her the sun . She asked Resident #2 to draw up the . Resident #2 drew 11 units of . Resident #2 was instructed by Employee B to push up on the needle a little bit, to the 10 line. Resident #2 pushed the syringe up and 10 units were then verified.

On at 1:18 pm Employee A stated on the 16th 2015), she signed the MOR that she gave Resident #2 her 8 AM & , but she stated she did not give the the morning of because Resident #2 ' s sugar was 100 that morning. The record recorded the was not given. On Resident #2 ' s sugar was recorded as 93. The log records no was administered, however, the MOR records it as being administered. Employee A stated that the MOR on appears as if it was given, but confirmed it was not given, it was held because of the low sugar.

On at 1:20 pm an interview with the administrator stated she comes out to the facility and oversees everything, but she does not look at the records. She said she will have to start reviewing all of the records.

2)
A review of Resident #3 ' s record on revealed a diagnosis of . Her Resident Health Assessment (1823) dated revealed that she required a regular diet and requires medication administration. Her record revealed a prescription dated which read to increase the AM dose to 25 units & keep the PM dose at 20 units. No orders were observed for parameters.
Review of Resident #3 ' s 2015 MOR revealed an order for , 20 units in the AM and 20 units in the PM. The AM dosage had a line drawn through it and 25 units was written. This was signed on by the ARNP.
Review of the shot record for Resident #3 found that it recorded that her was held on the morning of

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, 23, and 25 of 2015. Her [illegible] sugar on the morning of , 2015 was recorded as 84 and no [illegible] was recorded as given. On !015 there was no documentation of [illegible] sugars or [illegible] On , 2015 at 8 am Resident 3 ' s [illegible] sugar was 79 and on , 2015 her [illegible] sugar was 87 at 8 am. Further review revealed on , , and , and , [illegible] sugars were recorded as being below 100. On each of those dates, [illegible] was recorded as being held. (Photographic evidence)
On [illegible] at 12:20 pm an interview with Resident #3 revealed her [illegible] sugar was checked twice a day. Resident #3 stated that the staff hand her, her prefilled syringes. She reported that her family comes in and fills up her syringes for her.
On [illegible] at 2pm, an observation of the [illegible] for Resident #3 revealed 2 bags of prefilled syringes stored in the refrigerator. One bag was labeled with Resident #3 ' s name and read 20 units, PM. The other bag of [illegible] was labeled with Resident #3 ' s name and " 15 units , only in AM. " The 34 syringes in this bag were filled with 16 units of clear fluid. (Photographic evidence)
On [illegible] at 2:40 pm Employee A stated that Resident #3 ' s [illegible] gets held on the days her [illegible] sugar was below 100. She confirmed she would give Resident #3 her prefilled syringes from the refrigerator.

On [illegible] at 1:25 pm, an interview with the ARNP was conducted. She reported that she has been coming to the facility since 2014. She reported that Resident #2 was ordered to receive a [illegible] diet that is sugar free and lower carbs at the facility. She reported that she didn't think Resident #2 was capable of drawing up her own [illegible] The ARNP reported that the staff should not hold the long acting [illegible] ; they need to keep giving it, but to hold the short acting [illegible] when Resident #2 ' s [illegible] sugar is low. She reported there was documentation dated , for staff to hold the rapid acting [illegible] for Resident #2 if her [illegible] sugar was under 100. The ARNP stated that Resident #2 ' s [illegible] sugar should be checked 3 times a day. She reported that " it is a big problem " if Resident #2 is injecting all 50 units twice a day. She said she was not aware that the facility had unlicensed staff assisting Resident #2 with her [illegible] She reported that she was not aware that the facility was holding both of her [illegible] & [illegible] when the [illegible] sugar was 100 or less. The ARNP said holding the [illegible] will affect Resident #2 ' s [illegible] sugar. She said " it makes sense now because she couldn't figure out why the evening [illegible] sugars were running high. " She said for Resident #3, she may be able to inject herself. The ARNP stated that the staff should not be holding any [illegible] for Resident #3, because the [illegible] is long acting.
On [illegible] at 3:06 pm the ARNP arrived at the facility. She reported that no one has contacted her regarding questions or clarifications regarding Resident #2 or Resident #3 ' s [illegible]

Employee record review of Employee A revealed she was hired as a Resident Assistant [illegible] on [illegible] Review of her file revealed a Certified Nursing Assistant (CNA) license with an expiration date of [illegible] Employee A had a training certificate for assistance with self-administration with medication dated [illegible]

Employee record review of Employee B revealed she was hired as a Resident Assistant on [illegible] Employee B had a training certificate for assistance with self-administration with medication dated [illegible]

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Class II

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

Based on record review and staff interview, the facility failed to update the Medication Observation Record ' s (MOR) after assistance with medication for 3 of 3 sampled residents reviewed. (Resident #1, #2, #3)

The findings include:

Record review of Resident #1 MOR revealed the morning of ..... her medications were not signed as given. (Photographic evidence)
Record review of Resident #2 MOR revealed the morning of ..... her medications were not signed as given. (Photographic evidence)
Record review of Resident #3 MOR revealed the morning of ..... her medications were not signed as given. (Photographic evidence)
On ..... at 10:20 am, an interview with Employee A revealed she gave the residents their morning medication, but she did not sign the MOR ' s yet. She confirmed the medications were given before 8 am.
On ..... at 11:55 am, the administrator confirmed the MOR ' s must be signed after the medication was given. She said she has told her med techs many times that as soon as the medications are given, they must sign the MOR.
Class III

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

Based on observation and staff interview, the facility failed to ensure medications were properly stored, in their originally labeled container for 2 of 3 sampled residents. (Resident #2, #3)

The findings include:

On ..... at 10:50 am an observation of ..... in the refrigerator for Resident #2 revealed 2 bags with prefilled ..... syringes, filled with a clear fluid. Each bag had Resident #2 ' s name on it. One of the bags had 24 prefilled syringes of 50 units of an unknown substance in it. The second bag had 26 prefilled ..... syringes of 11 units with an unknown clear substance. (Photographic evidence)
On ..... at 2pm an observation of the ..... for Resident #3 revealed 2 bags of ..... stored in the refrigerator. One bag of syringes had 16 units and the other bag had 26 units. All her syringes were pre-filled with a clear unknown substance. One bag was labeled with her name, and it said 20 units, PM. The other bag of ..... was labeled with her name and 15 units ..... only in am. The 34 syringes were filled with 16 units of clear fluid. (Photographic evidence)
On ..... at 11:55 an interview with the Administrator stated she was not aware she could not have pre-filled

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in the refrigerator if the resident or family was doing it.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

Mrs. Warrenrina L. Henderson
5626 Soutel Dr.
Jacksonville, FL 32219

Dear Mrs. Henderson,

This letter reports the findings of a licensure complaint survey (CCR#2015003782) conducted on , 2015 by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

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

1) ST-A0052- Class II- Assistance with Self-Administration of Medication

The facility failed to provide assistance with self-administration with medication according to Florida Statute (FS) 429.256 by allowing unlicensed staff to doses, use independent judgement by withholding without a physician's order, and assisted residents with unlabeled prefilled syringes for 2 of 3 sampled residents (Resident #2 & #3). This resulted in high sugar readings for Resident #2 and low sugar readings for Resident #3. Resident #2 & Resident #3 had recent medication changes, due to their sugar readings.

2) ST-A0007- Class II- Admission Criteria

The facility failed to provide a therapeutic diet to Resident #3, per their physician's order upon admission. This resulted in Resident #3 having elevated sugar readings and having changes made to her medications, due to these readings.

You are directed to complete the following tasks:

1) Implement a written, detailed plan of how the facility will have each resident currently residing at the facility assessed for specialized diet needs and level of assistance with medications, by their health care provider. The assessment will include obtaining a Resident Health Assessment (1823), dated after for all residents currently residing in the facility. The assessment must clearly document any residents that receive and what level of assistance is required for and glucose monitoring. Any resident who is deemed inappropriate for continued residency according to Florida Administrative Code 58-A018 or is assessed to have needs that the facility cannot meet, the facility will give required written notice and ensure safe transfer of the individual to a location in which their needs can be met,

2727 Mahan Drive • Mail Stop #
Tallahassee, FL 32308
AHCA.MyFlorida.com

921 North Davis Street, A-115
Jacksonville, Florida 32209
(904) 798-4201
Fax (904) 359-6054

with coordination and input from the resident and their primary guardian/ Power of Attorney. Notice will be sent to the Agency for Health Care Administration, no later than , of residents who were deemed inappropriate for continued residency. The notification must include the resident's name, Power of Attorney or guardian's name and phone number where they can reached, and location of discharge.

2) The facility must ensure all unlicensed staff providing assistance with self-administered medications complete a minimum of 2 hours of continuing education training on providing assistance with self-administration of medications. The consultant must use the training course approved by the Department of Elder Affairs that is posted on their website at http://elderaffairs.state.fl.us/doea/pubs/pubs/2012Med_Guide.pdf. All unlicensed staff must complete this training no later than , 2015. This documentation must be kept on file at the facility, and be available for review by the Agency.

3) The facility must use the updated 1823's for all residents, as required in paragraph #1, to determine any specialized dietary needs. The facility must have a one-time consultation with a registered dietician to discuss any specialized menus required for the census and must update the facility's current menu to address the needs of the residents. This consultation must occur by . . . . . Written documentation of the consultation, the results of the consultation, and a copy of the registered dietician's license must be kept on file at the facility for review by the Agency.

All required documentation set forth above, should be directed to the attention of Mrs. Jana Meyering, Health Facility Evaluator Supervisor and sent to:

Agency for Health Care Administration
Health Quality Assurance, Jacksonville Field Office
Attention: Jana Meyering
921 N. Davis Street, Bldg. A, Suite 115
Jacksonville, FL 32209
Phone: (904) 798-4201
Fax: (904) 359 - 6054

Nothing in this Directed Plan of Correction limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call . . . . Laura Manville, Survey and Certification Support Branch, at 727-552-1955 or Jana Meyering, Jacksonville Field Office, at 904-798-4201.

Sincerely,

Received
Brittney Warren, Caregiver
July 7, 2015

Joe Snyder for Jana Meyering

Jana L. Meyering, Q.I.D.P.
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JD/JM/RED/sm

Brittney Warren

Spoke with Administrator by phone at 3:30 on July 7th and informed her it was being dropped off