STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965167	06/29/2015
NAME OF PROVIDER OR SUPPLIER **SILVER PINES ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **2360 MADRID AVENUE S.E.** **PALM BAY, FL 32909**	

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

0000 Initial Comments

A re-licensure survey with Limited Nursing Services (LNS) was conducted on . Silver Pines Assisted Living had deficiencies found at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and interview the facility failed to ensure that 1 of 3 sampled residents record reviewed had a completed health assessment that addressed all the required criteria (#3).
Findings:
Resident record review for resident #3 revealed a health assessment report AHCA form 1823 was dated . Continued review revealed the assessment did not indicate the type of assistance the resident needed with his medications. That portion of the form was blank.
In an interview with the administrator on at approximately 4 PM, who stated she overlooked the form.
Class III

0025 Resident Care - Supervision

Based on observations and record review the facility failed to ensure it provided appropriate services to meet the needs of 2 of 3 sampled residents (#2 and #3) a pain medication ahead of schedule.
Findings:
In an interview with resident #2 on at approximately 10:30 AM, who stated she had taken all her morning medications.
Observations at approximately 12 PM on noted staff #C took the medications from the locked medication cabinet. Took a plastic cup, read the label and put the pills one by one in a cup and placed on the table by were resident #2 was going to sit to eat lunch. One of the medications was a pain medication. The prescription label dated indicated 50 mg one every 6 hours. The Medication Observation Record (MOR) listed 50 mg every 6 hours and scheduled for 8 AM, 2 PM, and 8 PM. The MOR indicated the was given at 8 AM. Per healthcare provider's instruction the medication was to be given every 6 hours then if given at 8 AM, it was due at 2 PM, not 12 PM.
Continued observations at approximately 12 PM on noted staff #C took the medications from the locked medication cabinet. Took a plastic cup, read the label and put the pills one by one in a cup and placed on the table by resident #2 was going to sit to eat lunch. One of the medications was a pain medication. The prescription label dated indicated 50 mg take 1 every 6 hours. The Medication Observation Record (MOR) listed 50 mg take 1 or 2 tablets every 6 hours as needed for pain scheduled for 8 AM, 2 PM, and 8 PM. The MOR indicated the was given at 8

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AM. Per healthcare provider's instruction the medication was to be given every 6 hours as needed for [redacted] then if given at 8 AM, it was due at 2 PM, not 12 PM.
In an interview with the administrator on [redacted] at approximately 4 PM, who stated she would speak with the staff.
Class III

0052 Medication - Assistance with Self-Admin

Based on observations the facility failed to ensure the unlicensed staff who assisted with self-administration of medications followed the correct procedure when she provided assistance with self-administration to 3 of 3 medication passes sampled residents (#1, #3 and #4).
Findings
Observations during the medication pass on [redacted] at approximately 12 PM staff # C took the medications from the locked medication cabinet. Took a plastic cup, read the label and put the pills one by one in a cup and placed the cup on the table by where resident #2 was going to sit to eat lunch.
Continued observations of the medication pass noted that the staff #C continued with the same process. She took the medications from the locked medication cabinet. Took a plastic cup, read the label and put the pill in the cup and placed on the table by where resident # 4 was going to sit to eat lunch.
Staff #C continued the same process when she assisted resident # 3 with her medications. The staff took the medications from the locked medication cabinet. Took a plastic cup, read the label and put the pill in the cup and placed on the table by where the resident was going to sit to eat lunch.
After she placed the plastic cups one by one on the table she called the residents to come eat. She did not observe the residents take their medications, she continued serving food and cleaning up in the kitchen.
In an interview with the administrator on [redacted] at approximately 4 PM, who offered no comment.
Class III

0078 Staffing Standards - Staff

Based on observations, record review and interviews the facility failed to ensure that all staff were assigned duties consistent with his/her level of education, training, preparation, and experience and allowed unlicensed staff to conduct [redacted] sugar testing and exercise judgment as to how much medication was needed to 1 of 3 sampled residents (#3).
Findings:
In an interview with the family of resident #3 on [redacted] at approximately 11:30 AM who stated the CNAs (certified nursing assistants) did the [redacted] sugar testing for resident #3 and sometimes gave her the [redacted] too. Any of the [redacted] S's whichever was there.
In an interview with staff #C on [redacted] at approximately 1PM who stated the unlicensed staff conducted

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SILVER PINES ASSISTED LIVING	2360 MADRID AVENUE S.E. PALM BAY, FL 32909

SUMMARY STATEMENT OF DEFICIENCIES
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the sugar testing for resident #3 and sometimes gave her the too.
Resident record review revealed a health assessment dated that listed diagnoses of type II, and . Her cognition was indicated as . A healthcare provider's order indicated FS (fasting sugars) to a/c (twice daily before meals) meals with SC (sliding scale) Prescription dated indicated Take with sugars before meals and at bedtime and inject per s/s Target 70- 200- ; 201 - 250 - 2U; 251- 300 - 4 U; 310-350- 6; 351- 400 - 8 U; greater than 400 10U and call doctor, prescription dated 26 every morning and prescription label dated indicated inject 55 Units every morning.
The glucose log dated 2015 indicated sugars twice daily (AM & PM). The log noted that the resident was given Novolg per sliding scale on 6/2, 6/6/, 6/7, 6/8, and . The log contained the signatures of the staff who conducted the testing and administration. The log contained the signature of unlicensed staff.
The MOR listed 26 units every morning, Novolg Take with sugars twice daily according to sliding scale and every morning 30 units every morning. The log contained the signature of unlicensed staff.
In an interview with the administrator on at approximately 4 PM, who stated the resident was able to self -administer the injections and conduct the testing, the staff documented they observed her do it and how much she took.

Class III

N277 LNS - Resident Care Standards

Based on record review and interview the facility failed ensure that limited nursing services were only provided as authorized by a health care provider's order, a copy of which must be maintained in the resident's file, for 1 of 3 sampled residents (#2).
Findings:
Observation during the facility tour on at approximately 10 AM resident #2 was observed to have a
Resident record review revealed a health assessment report form 1823 dated that indicated the resident was , had diagnoses of
degenerative disk , (DDD),
, unsteady gait and . The review revealed that a healthcare provider's order for the changes was not available.
In an interview with the administrator and Registered Nurse on at approximately 3 PM, who stated she had changed the residents but did not have any written documentation.
Class III

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N278 LNS - Records

Based on record review and interview the facility failed ensure that nursing progress notes were maintained and nursing assessments were conducted at least monthly for 1 of 3 sampled residents, who received limited nursing services (LNS) .
Findings:
Observation during the facility tour on at approximately 10 AM resident #2 was observed to have a
Resident record review revealed a health assessment report form 1823 dated that indicated the resident was had diagnoses of
degenerative disk (DDD),
unsteady gait and The review revealed there were no nursing notes that documented the changes. Monthly nursing assessments were not available.
In an interview with the administrator and Registered Nurse on at approximately 3 PM, who stated she had changed the residents but did not have any written documentation.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Silver Pines Assisted Living
2360 Madrid Avenue S.E.
Palm Bay, FL 32909

RE: Abbreviated relicensure w/LNS

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com