STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963902	09/11/2015
NAME OF PROVIDER OR SUPPLIER **AMERICARE ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **2992 DAY ROAD** **DELTONA, FL 32738**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR #2015006307 was conducted on /. Americare Assisted living had deficiencies found at the time of the visit.

0025 Resident Care - Supervision

Based on record review and staff and resident interview, the facility failed to ensure adequate staffing and/or supervision to prevent for 5 of 13 sampled residents. (Residents #13, #3, #10, #11, & #8)

The findings include:

1. The Administrator on / at 10:00 a.m. stated the facility did not have a written policy and procedure to prevent in the facility. However, any time a resident has a , an incident report needed to be completed and the family/ resident representative and physician needed to be notified.

2. Resident #13 on / at 10:30 a.m. stated that she was not happy about having to wait for a long time on the floor until someone could assist her this morning. She slid onto the floor and crawled out to the hallway and flagged down the one staff member working, Employee H. Employee H stated she could not lift her so she had to wait. Resident #13 stated staffing was not good especially overnight. She heard the day shift staff come in, but they would not help her either. Review of the resident's chart at / at 3 p.m. did not reveal any incident report or observation note of this event.

3. Employee H was interviewed on / at 2:19 p.m. She stated she worked last night until this morning (/ until 7 a.m.). She stated around 6:30 a.m. she was assisting Resident #3 in the shower when she heard someone yelling for help. She left Resident #3 in the shower by herself (posing risk for) and went to look for the resident who was calling for help which was Resident #13. The resident was on the floor. She stated she could not lift the resident by herself so she called the supervisor (Employee B) on the telephone. She stated that Employee B told her to wait for the day shift to come in and lift her off of the floor. She worked by herself for the whole overnight shift. If someone on her shift, she would call the supervisor or non emergency 911 for assistance to lift the resident. She stated when a day shift arrived, the front door was locked so there was a delay in them coming into the building. Eventually another resident opened the door for the day time staff.

On / at 2:35 p.m Employee B was interviewed. She confirmed she received a call this morning around 6:30 a.m. from Employee H about two residents who had and were on the floor. Also mobile X-ray came into the building for another resident. There were several issues going on at once and one employee could not do them all by herself. Employee H stated she could not lift any resident

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off the floor by herself; therefore Employee B as the supervisor made a judgement call to wait for the dayshift to arrive.

4. Resident #10 was interviewed on /_/_ at 12:50 pm. He stated he had a last week in his . He was sitting at his table and leaned sideways and . He was able to pull himself back into his wheelchair and did not sustain any injury. He told the staff the next day.

The Administrator on / at 1:02 pm stated she did not have a report of this incident. The facility's observation log on revealed that the resident had a small on his left arm. A small amount of was on his bed. He stated that he , but got up by himself. He stated he sometimes feels weak and since his . The facility did not complete an incident report per facility policy for this resident.

5. Resident #10 also reported to staff that he heard commotion coming from the (Resident #11) next door in the middle of the night a few weeks back. He reported it to the staff the next day that he believed the resident might have . The facility's observation log dated revealed Resident #11 complained of right knee pain and might have out of bed overnight. She complained of being stiff and limping all morning. The right lower back had a red . Staff applied ice to the resident's " right knee. The clinical record did not reveal an incident report for Resident #11. The Administrator confirmed this on / at 1:02 pm.

Resident #11 had a health assessment on revealing she had , and unsteady gait. She had a history of and needed supervision with ambulating.

6. On at 10:55 a.m. Resident #8 was interviewed. She stated she last week and had to wait 3 hours to get help off of the floor. They need more staff working overnight. Employee A on / at 11:05 a.m. stated she was at the medication cart around 6 a.m. when she saw Resident #8 sitting on the floor by her doorway. The resident told her that the resident slipped and she was ok. She stated the resident told her not to fill out an incident report so she did not do one.

7. The Administrator on / at 1:30 p.m. confirmed that each time a resident , the staff should complete an incident report and notify family and physician. She confirmed the staff did not so for Residents #13, #10, #11, and #8. She also confirmed she had only one staff at night to care for all of the residents in the building (35 residents) with - of them needing assistance with toileting and or checking and changing briefs. They used to have two staff members working at night, but the owner only wanted one staff member.

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Class III

0029 Resident Care - Nursing Services

Based on record review and staff interview, the facility failed to arrange for nursing services for a resident after a [illegible] for 1 of 14 sampled residents, Resident #11.

The findings include:

The facility's observation log dated [illegible] revealed Resident #11 complained of right knee pain and might have [illegible] out of bed overnight. She complained of being stiff and limping all morning. The right lower back had a red [illegible]. Staff applied ice to the resident's [illegible] right knee.

The Supervisor, Employee B (non licensed staff), was interviewed on [illegible] at 1:15 p.m. She stated the resident was a respite patient from [illegible] and admitted by the resident's daughter. She stated she wrote the observation note on [illegible] when the resident stated she might have [illegible] in the middle of the night. Resident #11 complained of right knee pain. Nothing else was done at this time. Later that day she still complained of pain and the right knee was [illegible]. Employee B had called the physician and received a telephone order to apply the ice 20 minutes on and 20 off to the knee and obtain an X-ray of the knee. Ice was applied 20 minutes on and off by Employee F. Documentation did not reveal that the resident's daughter was notified of the incidient.

Employee B on [illegible] at 1:17 p.m. stated she was unaware that she was not allowed to take a telephone order for ice to be applied and for a mobile X-ray. She also stated that no one assessed the resident for the amount of pain the resident was having or obtain additional orders for pain medication for that knee.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review, and staff interview, the facility failed to honor resident rights by not following their grievance process for 2 residents (Resident #9 and #4) and failed to ensure side rail physician orders were renewed annually for 1 resident (Resident #4), of 13 sampled residents.

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The findings include:

1. The son of Resident #9 was interviewed on .. at 3:10 p.m. He stated that the facility was not clean and it was understaffed. He spoke to the Administrator but it still continued.

2. Resident #4 on I/ at 9:35 a.m. stated she did not appreciate how Employee C treated her disrespectfully. She was always shouting, "move, get out of the way". She told the Administrator, but she did not do anything. She still does it. She also stated that staffing was not good over night and if she needed something she would have to wait sometimes up to 2 hours.

3. The Administrator was interviewed on . I/.. at 1:57 p.m. regarding their grievance policy. She stated she had a complaint from Resident #4 about Employee C and spoke with the employee. That was just her demeanor to speak with residents like that. She does not know if it got better. She did not write down this grievance and get back with the resident who made the complaint.

She also stated that the son of Resident #9 had complaints about the facility and he spoke directly to the owner. Then the owner told her. She stated one of the issues might have been about the environment but it was a while ago. She stated that they do not write down the complaints from residents or families. They just try to resolve them. She stated the owner could not be interviewed because he was on vacation. The Administrator stated she did not have any written grievances in the last few years.

The facility's Resident Grievance Procedure revealed if the grievance was not resolved, it should be written and submitted to the owner. If it was still unresolved, it may be filed with the local ombudsman. A resident representative shall assist with contacting the local ombudsman. This was not done for Resident #9 or Resident #4.

4. The bed of Resident #4 was observed on . I/.. at 10:30 a.m. It was observed to have 1/2 side rails in place. The clinical record revealed a physician's order on for the half side rails. The Administrator on I/ at 3:30 p.m. confirmed she did not renew this side rail order annually.

Class III

0054 Medication - Records

Based on record review and staff interview, the facility failed to have an accurate medication observation

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record (MOR) for 1 of 14 sampled residents, Resident #2.

The findings include:

Review of the and 2015 MORs revealed a physician ordered medication, 2 milligram (mg) per milliliter (ml), take 2mg as needed every 6 hours. is an anti- medication. It did not give an indication when to take this medication. The medication label read 2mg/ml take 1 ml by mouth every 6 hours as needed for agitation. This was given up to 2 times a day in by non-licensed personnel.

The Administrator on / at 11:30 a.m. confirmed the medication label did not match the MORs because there was no indication for use on the MOR. She also confirmed that non-licensed staff gave as needed.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and staff interview, the facility failed to a provide a safe living environment with the potential to affect all 37 residents on the current census.

The findings include:

An observation was conducted of the facility on / at 9:15 AM. The following areas of concern were noted. The facility carpet was observed with multiple stains, frays and an iron mark. Throughout the facility, the carpet, tile or linoleum both in the common areas of the facility and in residents were sticky to the point this surveyors shoes would stick when walking. In the main dining , floor tiles were cracked and in poor repair with food particles and paper of white debris were seen on the floor. There were 6 ceiling fans in the Main Dining one in a small library off of the dining a thick layer of dust on all the blades. French doors in the main dining to an outdoor seating area where broke, and were not able to open the doors freely. Black biological growth was observed on the air vents and sprinkler system in the main lobby seating area as well as large brown colored stains on the ceiling. Resident # flooring had medium size holes

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that exposed concrete flooring and the bed had 2 small stains of brown color on the residents sheets. The garbage can in the resident's full of soiled undergarments and the a strong smell of stool and . The can was never emptied during the survey. The doorway to # had holes to the door jam and in poor repair. Resident # , door to entrance of apartment is observed with a brown like substance on the door. # had a large spider on the floor of the entry way to the apartment # had paint peeling off the wall around the air conditioning unit and black biological growth seen around the unit. A a clump of hair/ string was observed on the railing outside of # and remained until time of the exit . Resident # was missing a cabinet door from the vanity in her . Photographic evidence was obtained of thses observations.

An interview was conducted with the administrator on / at 11:00 AM. The administrator stated " The owner came down from Chicago a few weeks ago and looked at the facility for repairs that it needed". The administrator could not provide a time frame when repairs are to be done or any estimates of the repairs needed. She stated, "It should be done before Christmas."

An interview was conducted with the Administrator on / at 11:55 AM and she confirmed the facility floors are " sticky" and the staff cleans the floor with a no rinse floor cleaner, "Fabuloso". She stated, "That could be the reason why our feet stick to the floors".

An interview was conducted with the Administrator on / at 12:50 PM. She confirmed the ceiling fans were dirty and haven't been cleaned for the past 2 months.

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Americare Assisted Living
2992 Day Road
Deltona, FL 32738

RE: CCR #2015006307

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2015 by a representative 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 a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 30, 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. Should you have any questions please call this office at .

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LW/JM/sm
Enclosure
XG90

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