STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966623	10/14/2015
NAME OF PROVIDER OR SUPPLIER **STEPHANIE'S LOVE & CARE FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3056 W 1ST STREET JACKSONVILLE, FL 32254**	

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

0000 Initial Comments

On , 2015 a biennial licensure with Limited Mental Health survey was conducted at Stephanie's Love and Care Assisted Living. Deficient practice was identified during the surveys.

0007 Admissions - Criteria

Based on observation, resident interview, record review and staff interview, the facility failed to ensure 1 (#3) out of 4 sampled residents was appropriate for admission to the facility.

The findings include:

During interview with Resident #3 on at 9:20am he was asked why he had his foot up on the end of the bed. He stated he has a on his left heel. He stated he was told by the nurse to keep his foot elevated. She told him that it would heal faster if he did so. He stated the nurse comes every two days and changes the dressing.

Review of the Health Assessment for Resident #3 dated revealed the resident was assessed as having a on his left heel. He was assessed as having a G-tube (-tube) that required flushing with water. His medications were to be crushed and put in vanilla pudding. His diet order was mechanical soft with honey thickened liquid.

Review of the Medical Certification For Nursing Facility/Home-And Community-Based Services Form (Agency for Health Care form 3008) dated revealed the resident was assessed as having a , on his left heel, mechanical soft diet with thickened liquids and requiring medications to be crushed and put in pudding.

A record review for Resident #3 revealed no documentation regarding the care for the on his left heel.

An observation of the administrator assisting Resident #3 with his medications was made at 9:50 am. She did not crush his oral medications, instead giving them to him whole with a glass of water with no thickener in it. The resident accepted the medications and water and swallowed them.

During an interview with the facility administrator at 10:10 am she stated Resident #3 does have a on his heel. She stated the Home Health Agency (HHA) nurse has told her that it is almost healed. She stated she was aware of the when she admitted him but she thought because it was almost healed she could take him. She stated she has never actually seen the

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She stated she does not know what stage the is right now and the HHA nurse does not give her documentation regarding the treatment she provides for the '. She stated "I wouldn't have taken him if I didn't think I could take care of him." She stated he is very independent except for the care and that is done by the HHA nurse. She stated he came to the facility with a g-tube, however, she was not aware of it because he did not take any medication or food through the tube. She stated that the g-tube has been taken out. It was removed on . She stated the HHA nurse first saw him on . That's when the resident first told her about his g-tube. She stated that the nursing home had the appointment set up to have it removed but she was not made aware of it until she got a letter from the nursing home with the appointment date, time and location on it. She was shown the Health Assessment form dated that indicated the , the g-tube, the medication order to crush his medications and the diet order. She stated that the Health Assessment was the one she got when she picked him up at the nursing home. She stated she didn't see that he had a g-tube and it didn't come to her attention until the resident told her. She stated the resident told her that he doesn't have to have his medications crushed, a mechanical soft diet or thickened liquids. She stated he told her there was no problem with him swallowing and he didn ' t know why they put a g-tube in him in the first place. She stated she did not know that she should have gotten a new assessment or new physician's orders to change the resident's medication from crushed to whole and the diet order from mechanical soft with thickened liquids to regular texture and thin liquids.

During a telephone interview with the Home Health Agency nurse on at 9:43 am she confirmed she is the nurse that provides the care for Resident #3. She stated she comes to the facility every two days and stated she estimates the to be a measuring approximately 1.0 x 1.6 with a little bloody drainage. She stated the resident was admitted to the facility with a . She wasn't sure about the size at the time and referred this surveyor to the HHA main office to obtain documentation. She stated that in her assessment the has gotten much smaller and is almost completely healed.

During an interview with Resident #3 on at 10:40 am he stated the g-tube was placed while he lived at the nursing home. He stated he was told he needed it because he might have a problem swallowing. He stated he never had a problem swallowing and doesn't know why he had it at all. He stated eventually he asked to eat by mouth and Speech worked with him to make sure he could. He stated that there was never an appointment made to take the tube out while he lived at the nursing home. He stated after he moved to this facility he never used the tube for food or medications. He stated a few weeks after he was here he went to the doctor and had it removed. He stated he doesn ' t want his food mechanically softened or his medications crushed.

Review of the documentation received from the HHA dated the physician's assistant documented the ' on Resident #3 's left heel was a , measuring a 3cm and he had a

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Endoscopic ( ) tube for . The note read that the resident told the physician ' s assistant that the tube had not been used in about 3 weeks.

During an observation of the lunch meal service on from 12:45pm until 1:10pm Resident #3 was served food that was not mechanically softened and liquids with no thickener.

Class III

0025 Resident Care - Supervision

Based on observation, resident interview, record review and staff interview the facility failed to monitor the general health and wellbeing of 1 (#3) of 4 sampled residents.

The findings include:

During observation of and an interview with Resident #3 on at 9:20am he was asked why he had his foot up on the end of the bed. He stated he has a on his left heel. He stated he was told by the nurse to keep his foot elevated. She told him that it would heal faster if he did so. He stated the nurse comes every two days and changes the dressing.

Review of the Health Assessment for Resident #3 dated revealed the resident was assessed as having a on his left heel. He was assessed as having a G-tube (-tube) that required flushing with water. His medications were to be crushed and put in vanilla pudding. His diet order was mechanical soft with honey thickened liquid.

Review of the Medical Certification For Nursing Facility/Home-And Community-Based Services Form (Agency for Health Care form 3008) dated revealed the resident was assessed as having a on his left heel, mechanical soft diet with thickened liquids and requiring medications to be crushed and put in pudding.

During the document review no policy and procedure was found for Third Party Services.

A record review for Resident #3 revealed no documentation regarding the care for the on his left heel.

Review of the documentation received from the HHA dated the physician's assistant documented the on Resident #3 ' s left heel was a , measuring a 3cm and he had a Endoscopic ( ) tube for . The note read that the resident told

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the physician ' s assistant that the tube had not been used in about 3 weeks.

During an interview with the facility administrator at 10:10 am she stated Resident #3 does have a on his heel. She stated the Home Health Agency (HHA) nurse has told her that it is almost healed. She stated she was aware of the when she admitted him but she thought because it was almost healed she could take him. She stated she has never actually seen the . She stated she does not know what stage the is right now and the HHA nurse does not give her documentation regarding the treatment she provides for the . She stated "I wouldn't have taken him if I didn't think I could take care of him." She stated he is very independent except for the care and that is done by the HHA nurse. She stated he came to the facility with a g-tube, however, she was not aware of it because he did not take any medication or food through the tube. She stated that the g-tube has been taken out. It was removed on . She stated the HHA nurse first saw him on . That's when the resident first told her about his g-tube. She stated that the nursing home had the appointment set up to have it removed but she was not made aware of it until she got a letter from the nursing home with the appointment date, time and location on it. She was shown the Health Assessment form dated that indicated the ; the g-tube, the medication order to crush his medications and the diet order. She stated that the Health Assessment was the one she got when she picked him up at the nursing home. She stated she didn't see that he had a g-tube and it didn't come to her attention until the resident told her. She stated the resident told her that he doesn ' t have to have his medications crushed, a mechanical soft diet or thickened liquids. She stated he told her there was no problem with him swallowing and he didn ' t know why they put a g-tube in him in the first place. She stated she did not know that she should have gotten a new assessment or new physician ' s orders to change the resident ' s medication from crushed to whole and the diet order from mechanical soft with thickened liquids to regular texture and thin liquids.

During an interview with the administrator on at 1:55 pm she stated she does not have a written policy and procedure for Third Party Services. She stated that Resident #3 is the first resident she has admitted that required third party services (Home Health care) and she has just been having discussions with the nurse when she comes to the facility to provide care to Resident #3. She stated she would develop a written policy and procedure.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on record review and staff interview the facility failed to provide a written policy and procedure for receiving and responding to grievances, complaints and residents' recommendations to change facility policies and procedures.

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The findings include:

A biennial survey was conducted on / at the facility. During the document review no grievance policy was found.

During an interview with the administrator on at 1:45 pm she stated she does not have a written policy and procedure for grievances. She stated that residents are instructed to write their concerns on a piece of paper and put it in " the box " on the table in the living . She stated most of the residents ' concerns are made known to her verbally. She stated she would develop a written policy and procedure.

Class III

0031 Resident Care - Third Party Services

Based on resident interview, record review and staff interview the facility failed to develop a written policy and procedure to coordinate Third Party services for 1 (#3) out of 4 sampled residents.

The findings include:

A biennial survey was conducted on at the facility. During the document review no policy and procedure was found for Third Party Services.

During an interview with the administrator on at 1:55 pm she stated she does not have a written policy and procedure for Third Party Services. She stated that Resident #3 is the first resident she has admitted that required third party services (Home Health care) and she has just been having discussions with the nurse when she comes to the facility to provide t care to Resident #3. She stated she would develop a written policy and procedure.

Class III

0056 Medication - Labeling and Orders

Based on record review, observation and staff interview the facility failed to obtain a written order for medications to be given whole, food to be served as regular texture and liquids to be served with no thickener for 1 (#3) out of 4 sampled residents.

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The findings include:

Review of the Health Assessment for Resident #3 dated revealed the resident was assessed as requiring his medications to be crushed and put in vanilla pudding and his diet order was mechanical soft with honey thickened liquid.

Review of the Medical Certification For Nursing Facility/Home-And Community-Based Services Form (Agency for Health Care form 3008) dated revealed the resident was assessed as requiring a mechanical soft diet with thickened liquids and requiring medications to be crushed and put in pudding.

An observation of the administrator assisting Resident #3 with his medications was made on at 9:50 am. She did not crush his oral medications, instead giving them to him whole with a glass of water with no thickener in it. The resident accepted the medications and water and swallowed them.

During an observation of the lunch meal service on from 12:45pm until 1:10pm Resident #3 was served food that was not mechanically softened and liquids with no thickener.

During an interview with the facility administrator at 10:10 am she stated Resident #3 told her that he doesn ' t have to have his medications crushed, a mechanical soft diet or thickened liquids. She stated he told her there was no problem with him swallowing. She stated she did not know that she should have gotten a new assessment or new physician's orders to change the resident ' s medication from crushed to whole and the diet order from mechanical soft with thickened liquids to regular texture and thin liquids.

Class III

0085 Training - Nutrition & Food Service

Based on record review and staff interview the facility failed to ensure the administrator had completed two hours of continuing education as the Food Service Designee on an annual basis.

The findings include:

A biennial survey was conducted on at the facility. Review of the employee file for the administrator revealed a certificate for completion of a training on food service for 1 hour of credit.

Interview with the administrator on at 11:30 am revealed she thought 1 hour was all that was required. She stated she would get more training to equal the required 2 hours.

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Class III

0093 Food Service - Dietary Standards

Based on record review and staff interview the facility failed to retain menus with substitutions noted on file in the facility for 6 months.

The findings include:

A biennial survey was conducted on ../..... at the facility. Review of the substitution log for menu changes revealed it was blank.

During an interview with the administrator on at 12:20 pm she stated that she does not write down the substitutions she makes to the menu. She stated that she makes substitutions to the menu for Resident #3 almost every day because he is a picky eater and he is a and cannot or will not eat much of what is on the menu.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
Stephanie's Love & Care Facility
3056 W 1st Street
Jacksonville, FL 32254

Dear Administrator:

This letter reports the findings of a state biennial licensure with Limited Mental Health 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 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 [redacted], 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 this office at .

Sincerely,

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

JD/JM/sm
Enclosure
XG90

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