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	AL11967775	**10/25/2015**
NAME OF PROVIDER OR SUPPLIER **CHRISTIE'S PLACE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **471 ALMANSA STREET NE PALM BAY, FL 32907**	

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0000 Initial Comments

Complaint Investigation #2015010659 was conducted from [illegible], 20, 23, 24 and [illegible]. Christie's Place Assisted Living Facility had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and interviews, the facility failed to provide properly completed Agency for Health Care Administration (AHCA) 1823 Health Assessments for 4 of 5 residents (#2, 3, 4 & 5).

Findings:

1. On [illegible], resident #2's AHCA 1823 Health Assessment failed to provide a legible signature and date on the space required for physician's date of assessment.

2. On [illegible], resident #3's AHCA 1823 Health Assessment failed to provide documentation of what services are to be offered and arranged by the facility.

3. On [illegible], resident #4's AHCA 1823 Health Assessment did not document if the resident's needs could be met at an Assisted Living Facility. Resident #4's AHCA 1823 Heath Assessment failed to document if the resident needed help taking medications. Resident #4's AHCA 1823 Health Assessment also failed to provide documentation of what services are to be offered and arranged by the facility.

4. On [illegible], resident #5's AHCA 1823 Health Assessment failed to provide documentation of what services are to be offered and arranged by the facility.

On [illegible] at 9 AM, the facility administrator reviewed the AHCA 1823 Health Assessments of resident #2, #3, #4 and #5 with the surveyor and stated she did not have an explanation as to why the AHCA 1823 Health Assessments were not properly completed.

Class III

0025 Resident Care - Supervision

Based on record review and interviews, the facility failed to maintain a safe environment by placing 4 of 5 residents at risk. The facility failed to document a written record of significant changes that required medical attention, and failed to complete tasks listed on an Agency for Health Care Administration (AHCA) 1823 health assessment, placing residents in jeopardy by leaving the facility without staff, and

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failed to follow established facility policy regarding resident ... (#2, 3, 4 & 5).
Findings:
In an interview on at 12:45 PM, the administrator stated that she has provided training on emergency procedures regarding ... The administrator stated that the staff is taught to remain calm, leave the resident in the location of the ..., not to move them, and call 911. The administrator stated that staff should put something under the resident's head.

1. Record review of the facility's adverse and incident log revealed documentation of a ... on .../... involving resident #5, who ... while attempting to use the rest .... Resident #5's progress notes did not contain information that the resident had been transported from the facility to a local medical treatment facility because of back pain.
Review of the Agency for Health Care Administration (AHCA) 1823 Health Assessment for resident #5 revealed that the resident required assistance with ambulation, bathing, dressing, self-care and toileting.
On ... at 9:40 AM, staff A stated that resident #5 was not at the facility because resident #5 had been transported to a local hospital because of back pain.
On ... at 3:30 PM, staff A stated that she allowed resident #5 to use the rest .... Staff A stated that she helped resident #5 up, and stated that she didn't call 911 because resident #5 did not want her to call.

2. On .../... at 10:15 AM, resident #4 stated that she had chest pain on .../... .... Resident #4 stated that she called 911. Resident #4 stated that she was transported by fire rescue to a local medical treatment facility.
Resident #4's progress notes failed to contain information that resident #4 had chest pain on .../.../..., that 911 was called, and that resident #4 was transported to a local medical treatment facility.
On .../... at 9 AM, the administrator stated that she was aware the resident #5 went to the hospital but was not aware that resident #4 had been transported to the hospital. The administrator asked resident #4 if she had gone to the hospital and resident #4 indicated that she had gone to the hospital with fire rescue. The administrator stated she did not know why it was not documented.

3. On , resident #3's AHCA 1823 health assessment revealed the resident is to have daily ..., ... checks and ... glucose checks. The assessment was signed by a physician on .../....
On at 9 AM, the administrator was asked how the facility documents the ... check and ... glucose monitoring for resident #3. The administrator stated that resident #3 refused to allow the administrator to test her ... glucose. The administrator stated she was unaware if the testing for the ... glucose and ..., ... was being conducted and reported to resident #3's primary care physician. The administrator stated she did not know if resident #3 had a ..., ... cuff or ... glucose meter. The administrator asked resident #3 to get the ..., ... cuff and ... glucose

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meter from her . . . . The administrator looked over the equipment. The administrator indicated this was the first time she had seen the equipment. The facility did not provide evidence of glucose and monitoring.

4. In an interview on / / at 3:14 PM, resident #3 stated that the administrator has left the residents alone in the past.

5. In an interview on / / at 3:25 PM, resident #2 confirmed that the administrator leaves the resident alone.
In an interview on at 9 AM, the administrator stated that she has left the residents alone at the facility. The administrator stated that she leaves the residents alone when she (the administrator) goes to the drug store or runs errands.
In an interview on at 12:01, a friend of resident #2 stated she has been at the facility when the residents have been left alone. In an interview on at 1:15 PM, resident #2's friend stated that she visits the facility on a regular basis. The friend stated that she has witnessed the residents of the facility being left unattended between 8 to 10 times by the facility administrator. The friend stated that when the administrator was confronted, the facility administrator banned her from coming to the facility to visit her friend.
Class II

0026 Resident Care - Social & Leisure Activities

Based on observations and interviews, the facility failed to provide an ongoing activities program for 5 of 5 residents (#1, 2, 3, 4 & 5).

Findings:

On / at 9:45 AM during a tour of the facility, it was observed that the facility provided a listing of resident activities on a white board in the common area. For / , the white board indicated that the activity for 10 AM was yoga, and 3 PM Bingo and Name that tune.

In an interview on / / at 9:55 AM, the administrator stated that the facility does not have any activities in place.

In an interview on / / at 10 AM, resident #3 stated that the facility does not have any activities beyond watching television.

On / at 10:10 AM, the residents were observed in the common area watching television. Staff A

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was questioned as to the status of the yoga activity. Staff A went to the refrigerator, pulled out a yogurt and stated, "No yoga".

In an interview on at 1 PM, resident #2 stated that the facility does not have any activities beyond watching television. Resident #2 stated that is all the residents are allowed to do.

In an interview on at 3:24 PM, resident #1 stated that he is "bored. We never do anything but watch television." Resident #1 stated the only activity is watching television.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on interviews and record reviews, the facility failed to provide an environment free from for 5 of 5 residents (#1, 2, 3, 4 & 5). The facility failed to treat a resident with consideration and respect for 1 of 5 residents (#2). The facility provided an environment that placed 5 of 5 residents at risk because of a language barrier (#1, 2, 3, 4 & 5).

Findings:

In an interview on at 9 AM, the administrator stated that she has yelled at the residents.

In an interview on at 3:55 PM, staff A stated, "Yes" about the administrator yelling at the residents. Staff A stated that the residents are afraid of the facility administrator.

In an interview on at 12:01 PM, a friend of resident #2 stated that she has observed the administrator yelling at residents, especially resident #2. The friend of resident #2 stated that the administrator talks tough to try and keep the residents afraid of her.

In an interview on at 3:10 PM, the friend of resident #3 stated that the staff are very abrupt with the residents and do not know how to talk with people. The friend of resident #3 stated that if the administrator does not get her way she gets very, "loud".

In an interview on at 1:15 PM, the friend of resident #2 stated she has witnessed the administrator yelling at all of the residents. The friend of resident #2 stated that because what she has witnessed the administrator yelling at residents, the friend of resident #2 confronted the administrator. The friend of resident #2 stated that the administrator stated to her that she was banned from the facility.

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On at 2:54 PM, resident #4 admitted that she is afraid of the administrator.

On / at 9 AM, in an interview with the administrator, when questioned about the discrepancy with the Medication Observation Records (MORs), the administrator took a deep breath and then yelled at staff A, "Why didn't you sign these over the weekend?"

In an interview on / at 9:40 AM, staff A did not understand the questions being asked in English. Staff A called the administrator to get clarification in Creole, her native language, as to what she was being asked.

In an interview on at 10:10 PM, staff A was asked about the snack she was preparing for the residents. Staff A smiled and stated "Yes". Staff A was asked additional questions regarding reports and staff A stated "Yes" or did not respond at all.

In an interview on at 3:06 PM, the daughter of staff A stated the day in which resident #5 , she had come to the facility to see staff A. The daughter of staff A stated that staff A asked her to call 911. The daughter of staff A stated that calling 911 is difficult for staff A because of the language. The daughter of staff A stated that the 911 operator asked too many questions for staff A to understand.

On / / , a record review was conducted on calls to service from the local law enforcement agency. The record review revealed 2 calls from the facility that provided concerns on a language barrier. Call #1 was made on at 12:23 PM, which read that "The caller keeps saying 'Needs police'." Call #2 was made on at 6:46 PM, which read "The caller keeps saying 'Yes' to all questions."

On / / , a record review was conducted of the work schedule for , 2015 and 2015. The record review revealed that on , staff A was on duty and working alone. The record review revealed that on / , staff A was on duty and working alone.

Class III

0054 Medication - Records

Based on record review and interviews, the facility failed to properly maintain Medication Observation Records (MORs) for 4 of 5 residents (#1, 2, 3 & 5). The facility failed to include the name of the resident's health care provider, the health care provider's contact number, and record immediately each time the medication is offered.

Findings:

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1. A record review was conducted on [redacted] for the MORs for resident #1. The MORs did not include the name of resident #1's health care provider and the health care provider's contact number. The MORs did not include documentation as to whether resident #1 received the following doses of medications:
[redacted] 8 AM and 8 PM doses for [redacted] and 8 AM dose for [redacted]
[redacted] tablet 8 AM doses for [redacted] and
Trisluperazime 8 AM doses for [redacted] and [redacted].

The space on the MORs for documentation was blank without a signature or initials.

2. A record review was conducted on [redacted] for the MORs for resident #2. The MORs did not include the name of the resident's health care provider and the health care provider's contact number. The MORs did not include documentation as to whether resident #2 received the following doses of medication:
Alatropam 8 AM does on [redacted] and [redacted], and 8 PM doses for [redacted] and [redacted].
Respiredore 8 AM and 8 PM doses for [redacted] and the 8 AM dose for [redacted]
[redacted] 8 PM doses for [redacted] and
Exybulpen 8 AM doses for [redacted] and [redacted].
Vit D-12 8 AM doses for [redacted] and [redacted].

The space on the MORs for documentation was blank without a signature or initials.

3. A record review was conducted on [redacted] for the MORs for resident #3. The MORs did not include the name of the resident's health care provider and the health care provider's contact number. The resident's MORs did not include documentation as to whether the resident received the following doses of medication:
[redacted] 8 AM dose for [redacted] and
Actopolol 8 AM dose for [redacted], and [redacted], and 8 PM dose [redacted] and [redacted].

The space on the MORs for documentation was blank without a signature or initials.

4. A record review was conducted on [redacted] for the MORs for resident #5. The MORs did not include the name of the resident's health care provider and the health care provider's contact number.

In an interview on [redacted] at 9 AM, the administrator stated that resident #5 was transported to a local medical treatment facility on [redacted] at 6:30 PM. The facility administrator stated that she actually

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provides the 8 PM medication at 6 PM dinner. The MOR indicated that resident #5 was provided her medication at 8 PM. The administrator stated that the MORs for resident #1, #2, #3 and #4 were signed and showed the copies. A photo of the residents' MORs were taken on . When the administrator was asked about the photos taken of all of the residents' MORs on / / that showed they were not signed, the facility administrator took a deep breath and proceeded to yell at staff A, saying "Why didn't you sign these like you were supposed to?"

Class III

0077 Staffing Standards - Administrators

Based on observations, record review and interviews, the administrator failed to ensure the facility provided a safe environment for 4 of 5 residents by leaving residents unsupervised, verbally abusing residents, maintaining an inaccurate admission and discharge log, not reporting an adverse incident, allowing untrained staff to work with residents, and allowing undocumented staff to work with residents (#2, 3, 4 & 5).

Findings:

1. On / at 3:14 PM, resident #3 was asked if the administrator had left the residents alone and said "Yes".
On / at 3:25 PM, resident #2 was asked if the administrator had left the residents alone and said, "Yes, the administrator leaves them alone a lot."
On at 9 AM, the administrator was asked if she leaves the residents alone and said, "Yes, when I go to the drug store and run errands."
On at 12:01 PM, the friend of resident #2 stated that she has seen the residents left alone.
On at 1:15 PM, a friend of resident #2 stated that she has witnessed the facility be left unsupervised a number of times by the administrator, not by other staff.

2. On / at 3:55 PM, staff A was asked if she had seen the administrator yell at residents and said, "Yes".
On at 9 AM, the administrator was asked about yelling at the residents and stated that she is "loud and gets very emotional". The administrator stated that she has yelled at resident #4.
On / at 9 AM, the administrator was questioned about how resident Medication Observation Records (MORs), not signed on / / as given on / / , could be signed on / . When the administrator became aware that photos had been taken on of the MORs, the administrator took a deep breath and then yelled at staff A, saying, "Why didn't you sign these over the weekend?"
On / at 12:01 PM, a friend of resident #2 stated that she has seen the administrator yell at

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residents. The friend stated that the administrator talks rough to the residents. The friend stated that the residents are afraid of the administrator.
On at 3:10 PM, a friend of resident #3 stated that she is concerned about the staff at the facility. The friend stated that the staff are very abrupt and do not know how to talk with people. The friend stated that the administrator gets "loud" if she does not get her way.
On at 1:15 PM, a friend of resident #2 stated she has witnessed the administrator yelling at residents. The friend stated that when she challenged the administrator about leaving the residents alone at the facility and yelling at the residents, the administrator told her she was banned from the facility.
On at 2:54 PM, resident #4 admitted that she is afraid of the administrator.

3. On , review of the facility admissions and discharges revealed that resident #1, #3 #4 and #5 currently living in the facility were not listed as having been admitted to the facility The admission and discharge log listed 5 additional residents living in the facility.
On at 9 AM, in an interview with the administrator, the administrator was asked about the accuracy of the admission and discharge log and she stated that it is the official log. The administrator stated that she thinks it is up to date. When asked why current residents #1, #3, #4 and #5 were not listed in the log, she stated she didn't know why.

4. On , review of the facility adverse and incident log revealed documentation of a on involving resident #5 while attempting to use the rest . On , review of the Agency for Health Care Administration (AHCA) 1823 Health Assessment for resident #5 revealed that the resident required assistance with ambulation, bathing, dressing, self-care and toileting.
On at 3:30 PM, staff A stated that resident #5 was independent and was allowed to use the rest her own. Staff A stated that she allowed resident #5 to use the rest her own. Staff A stated that she did not contact 911 after she because resident #5 asked her not to call. When staff A's daughter came to the facility, staff A's daughter called 911.
On at 2:35 PM, the Agency for Health Care Administration's (AHCA) Risk Management office was called. The employee at the office stated that the adverse incident report was not received from the facility.

5. On , review of staff A's employee file revealed that the administrator placed staff A on the schedule despite not having completed the following training; control, elopement response, incident reporting, resident rights, ( ) and assistance with the self-administration of medication.
On , review of staff C's employee file revealed that the administrator placed staff C on the schedule despite not having completed the following training; control, ADL (activities of daily living) and behavioral needs, ( ), safe food handling, assistance with

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the self-administration of medication and ( ) and First Aid.

6. On / , review of the administrator's 2015 work schedule revealed that both staff A and staff C were scheduled to work. On / , review of the administrator's 2015 work schedule revealed that staff A was scheduled to work.
On / / at 12:47 PM, staff A stated that the administrator had another staff member but she did not know the name of that person.
On at 12:55 PM, the administrator was asked who works at the facility besides the administrator and staff A. The administrator stated, "On occasion", she uses her daughter. The administrator refused to provide the name of her daughter.
On at 9 AM, the administrator stated that the work schedule that she used for the month of 2015 was incorrect. The administrator stated that staff A was off for two weeks. The administrator stated that she worked the time staff A was off.
On at 1:15 PM, a friend of resident #2 was asked the names of staff working at the facility, and stated she has seen the administrator, staff A, staff C and staff N.
On at 2:54 PM, staff A stated that a staff N has worked at the facility.
On at 2:54 PM, resident #2 stated that a staff N has worked at the facility.
On at 2:54 PM, resident #3 stated that a staff N has worked at the facility.
On at 2:54 PM, resident #4 stated that a staff N has worked at the facility.
On at 8:40 PM, in an interview with the administrator, the administrator stated that she does not know staff N. When it was stated that staff N had been identified, the administrator stated she did not work at the facility but staff N had considered working at the facility.
On / at 9:10 PM, staff N stated that she had worked at the facility. Staff N stated that she had worked two weeks in 2015. Staff N stated that she was paid by the administrator.

Class II

0078 Staffing Standards - Staff

Based on record review and interviews, the facility failed to provide evidence that 3 of 3 staff (administrator, staff A & staff C) completed a negative ( ) test annually.

Findings:

1. On / , review of staff A's employee file indicated that staff A completed her last test in 2011.

2. On , review of the administrator's employee file indicated that the facility administrator

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completed her last test in 2012.

3. On , review of staff C's employee file indicated that staff C completed her last test in 2012.

In an interview on at 9 AM, the administrator was asked to provide copies of current negative test for the administrator, staff A and staff C. The facility administrator stated that she could not provide the documents.

Class III

0079 Staffing Standards - Levels

Based on record review, interviews and observations, the facility failed to ensure that 1 of 3 staff members on site had access to facility and resident records (staff A), and failed to ensure that a staff member who completed courses in First Aid and ( ) was in the facility at all times (staff C).

Findings:

On / / at 9:40 AM, staff A stated that she was the only staff on duty until 7 AM on / . Staff A was requested to provide the following records: admission and discharge log, resident records, employee files, operating procedures for grievances, operating procedures for prevention and the incident log. Staff A contacted the administrator by telephone. The administrator stated that staff A had been directed to provide the requested records. The administrator stated that it was impossible for her to return to the facility because she was working in Palm Beach.

On / / at 9:55 AM, the administrator was advised that staff A had not located any of the records. The administrator stated that she would inform staff A how to locate the records.

On / / at 11 AM, when staff A was asked about the records that had been requested, she shrugged her shoulders.

On / at 9 AM, the administrator was asked to produce the records that had not been located on / by staff A. The administrator was observed to go into her private office and try to open the desk drawer with a key. When the key did not open the drawer, the administrator got a butcher knife from the kitchen and used it to open the drawer. When the drawer was opened, the administrator produced the missing records.

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A review was conducted of the facility's 2015 work schedule on / . The schedule for 2015 revealed that staff C worked from 7 AM on / to 7 AM on . The 2015 schedule revealed that staff C was the only staff assigned to work during those shifts.

A review was conducted on / regarding the 2015 work schedule for the facility. The 2015 revealed that staff A was scheduled to work from 7 AM on / until 7 AM on / .

A review was conducted on / regarding the employee file for staff C. Staff C's employee file did not contain evidence that she completed ( ) and First Aid training.

On / at 9 AM, the facility administrator was provided the opportunity to show the documentation for staff C completing and First Aid training. The facility administrator stated that she could not provide the documentation.
Class III

0080 Training - Core & Competency Test

Based on record review and interviews, the facility failed to ensure that the administrator participated in 12 hours of continuing education in topics related to assisted living every 2 years.

Findings:

A review was conducted on of the employee file for the administrator. The administrator's file indicated that she took ownership of the facility on . The file revealed that she completed CORE training on . The file did not reveal any continuing education training related to CORE since the initial training on .

On at 9 AM, the administrator was provided the opportunity to provide documentation for continuing training related to CORE. The administrator stated that she did not have any documentation of continuing education.

Class III

0081 Training - Staff In-Service

Based on record review and interviews, the facility failed to ensure that 2 of 3 staff completed the

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required one hour of in-service training related to [redacted] control (staff A & staff C), failed to ensure that 1 of 3 staff completed one hour of in-service training related to incident reporting and elopement (staff A), failed to ensure that 1 of 3 staff completed the in-service training related to resident rights (staff A), and failed to ensure that 1 of 3 staff completed the in-service training related to assistance with the activities of daily living and safe food handling practices (staff C).

Findings:

Review on [redacted] of staff A's employee file indicated that staff A had not completed the required training for [redacted] control, incident reporting, elopement and resident rights.

Review on [redacted] of staff C's employee file indicated that staff C had not completed the in-service training regarding [redacted] control, assistance with the activities of daily living and safe food handling practices.

On [redacted] at 9 AM, administrator was provided the opportunity to provide documentation of staff A having completed in-service training related to [redacted] control, incident reporting, elopement and resident rights. The administrator stated that she did not have any documentation to show that staff A had completed the missing trainings.

On [redacted] at 9 AM, the administrator was provided the opportunity to provide documentation of staff C having completed in-service training related to [redacted] control, assistance with the activities of daily living and safe food handling practices. The administrator stated she did not have any documentation to show that staff C had completed the missing trainings.

Class III

0082 Training - /

Based on record review and interviews, the facility failed to ensure that 1 of 3 staff had completed the training related to [redacted] ( ) and [redacted] ( ) (staff C).

Findings:

Review on [redacted] of staff C's employee file indicated that staff C had not completed the training related to [redacted] and [redacted].

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On / at 9 AM, the administrator was provided the opportunity to provide documentation of staff C having completed the training regarding and . The administrator stated she did not have any documentation to show that staff C had completed the missing trainings.

Class III

0083 Training - First Aid and

Based on record review and interviews, the facility failed to ensure that 1 of 3 staff had completed First Aid and ( ) training before working alone in the building (staff C).

Findings:

On / / , review of the staff schedule for the month of 2015 indicated that staff C worked 7 AM on / to 7 AM on . The staff schedule for the month of 2015 indicated that staff C was the only staff scheduled during these work hours.

On / , review of staff C's employee file indicated that staff C had not completed the training related to First Aid and .

In an interview on / at 9 AM, the administrator was provided the opportunity to documentation the First Aid and training for staff C. The administrator stated that she did not have any documentation to support staff C completing the training.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Based on record review and interviews, the facility failed to ensure 1 of 3 staff completed the 4 hour training related to Assistance with Self-Administration of Medication before working directly with residents and providing medication (staff C), and failed to ensure 1 of 3 staff completed the 2 hours of annual continuing education training related to the Assistance with Self-Administration of Medication (staff A).

Findings:

1. On / , review of the staff schedule for 2015 indicated that staff A had worked 19 days at 24 hours per day. The staff schedule for 2015 indicated that on dates staff A

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NAME OF PROVIDER OR SUPPLIER **CHRISTIE'S PLACE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **471 ALMANSA STREET NE** **PALM BAY, FL 32907**	

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worked, she was the only staff member scheduled.

On / / , review of staff A's employee file indicated that staff A completed her training for Assistance with the Self-Administration of Medication on . Staff A's employee file indicated that she completed 2 hours of continuing education training for the Assistance of Self-Administration of Medication in 2013. Staff A's file indicated she had not completed any other documented continuing education training for Assistance with the Self-Administration of Medication since the training in 2013.

In an interview on at 9 AM, the administrator was provided the opportunity to provide documentation that staff A had completed continuing education training related to the Assistance of Self-Administration of Medication for staff A. The administrator stated that she did not have any documentation to support staff A having completed the continuing education training related to the Assistance of Self-Administration of Medication.

2. On / , review of the staff schedule for 2015 indicated that staff C had worked 2 days at 24 hours per day. The staff schedule for 2015 indicated that the dates staff C worked, she was the only staff member scheduled.

On , review of staff C's employee file indicated that staff C had not completed the required 4 hours of training regarding the Assistance with the Self-Administrator of Medication.

In an interview on at 9 AM, the administrator was provided the opportunity to provide documentation that staff C had completed the 4 hours of training regarding Assistance of Self-Administration of Medication. The administrator stated that she did not have any documentation to support staff C having completed the 4 hours of training regarding Assistance with the Self-Administration of Medication.

On / / at 12:35 PM, staff A was observed providing medication to residents #1, #2, #3, #4 and #5.

Class III

0090 Training -

Based on record review and interviews, the facility failed to ensure 1 of 3 staff completed the required 1 hour of training related to ( ) (staff A).

Findings:

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On / / , review of staff A's employee file indicated that staff A had not completed the required 1 hour training regarding .

In an interview on / at 9 AM, the administrator was provided the opportunity to provide documentation that staff A had completed the 1 hour of training. The administrator stated that she could not provide any documentation that staff A had completed the required 1 hour of training.

Class III

0093 Food Service - Dietary Standards

Based on observation, record review and interviews, the facility failed to follow to a menu provided by a licensed dietitian for 4 of 5 residents (#1, 2, 3 & 4).

Findings:

On / , review of the facility planned menu indicated at lunch, residents would be served pasta with beef and cheese, mixed vegetables, salad with rice pudding and beverage.

Observation on / at 10:10 AM found staff A serving a morning snack of "Cheetos" to the residents. Staff A was asked if this was the snack that was approved by the dietitian. Staff A just smiled and shrugged her shoulders.

Observation on / / at 12:35 PM found residents not eating from the posted menu. The residents were eating soup with a ham sandwich, a drink and dessert.

In an interview on / at 11:30 AM, the licensed dietitian who signed the menu for the facility, stated that "Cheetos" would never be an approved snack for an assisted living facility. The dietitian stated that the recommended snack would be a fruit of some kind. The dietitian stated that she has prepared a detailed annual menu and it appears that the facility is not following that menu.

Class III

0160 Records - Facility

Based on record review and interviews, the facility failed to maintain an up-to-date admission and discharge log.

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Findings:

On / , review of the facility admission and discharge log did not list 4 of the 5 current residents, resident #1, #3, #4 and #5 or their dates of admission to the facility. The admission and discharge listed the names of 5 additional residents living in the facility and did not have their discharge dates.

During an interview on / , the administrator stated that the admission and discharge log reviewed is the official admission and discharge log of the facility. Without looking at the admission and discharge log, the administrator stated the log is correct. The administrator stated she did not know why 4 of 5 of the current residents are not listed in the admission and discharge log.

Class III

0161 Records - Staff

Based on record review and interviews, the facility failed to provide employment references for 3 of 3 staff (facility administrator, staff A & staff C).

Findings:

On / / , review of staff A's employment file did not provide documentation of employment references.

On , review of the administrator's employment file did not provide documentation of employment references.

On / , review of staff C's employment file did not provide documentation of employment references.

On / at 9 AM, the administrator stated that she could not provide any other documentation then what is in the employment files.

Class III

0163 Records - Resident. Penalties for Alteration

Based on record review, observations and interviews, the facility altered Medication Observation

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Records (MORs) for 4 of 5 residents (#2, 3, 4 & 5).

Findings:

1. A review was conducted on / for the MORs for resident #1. The MORs did not show any documentation as to whether the resident received the following doses of medications:
8 AM and 8 PM doses for , / , or 8 AM dose for
tablet 8 AM doses for / , / / and / .
Trisluperazime 8 AM for / , , / / and / .

The space on the MORs for documentation was blank without a signature or initials.

2. A review was conducted on / for the MORs for resident #2. The MORs did not showed any documentation as to whether the resident received the following doses of medications:
Alatropam 8 AM does on / , / / and / , 8 PM doses for , / and / / .
Respiredore 8 AM and 8 PM doses for / , / and the 8 AM dose for / / .
8 PM doses for / , / and / .
Exybulpen 8 AM doses for / , / and / .
Vit D-12 8 AM doses for / / , / , / / , / / and .

The space on the MORs for documentation was blank without a signature or initials.

3. A review was conducted on / / for the MORs for resident #3. The MORs did not show any documentation as to whether the resident received the following doses of medications:
8 AM dose for / / , / / and / .
Actopolol 8 am dose for / / , and / / , 8 PM dose , / and / .

The space on the MORs for documentation was blank without a signature or initials.

4. A review was conducted on / for the MORs for resident #4. The MORs did not show any documentation as to whether the resident received the following doses of medication:
Furoxmide 8 AM dose / /
8 AM for / .
Bazohopive 9 AM dose for / / and
8 AM dose for / / and / / .
8 AM dose for / / and / .
8 AM dose for / / and / / , 8 PM dose / and .

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8 AM dose for and /, 8 PM / and /.

The space on the MORs for documentation was blank without a signature or initials.

On at 9 AM, prior to starting an interview with the administrator, it was observed that the administrator had the MORs for resident #2, #3, #4 and #5, spread out over the dining and was seen signing them.

In an interview on / at 9 AM, the administrator was asked about the unsigned MORs and she stated that she had signed them all today. When it was brought to the attention of the administrator that photos of the MORs had been taken on / /, the administrator took a deep breath and then yelled at staff A, "Why didn't you sign these over the weekend?"

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on record review and interviews, the facility failed to file an adverse incident report involving the of 1 of 5 residents (#5).

Findings:

On / /, review of the facility adverse and incident log revealed documentation of a on / involving resident #5, indicating the resident while attempting to use the rest.

On /, review of the Agency for Health Care Administration (AHCA) 1823 Health Assessment for resident #5 revealed that the resident required assistance with ambulation, bathing, dressing, self-care and toileting.

On / / at 3:30 PM, staff A stated that she allowed resident #5 to use the rest her own. Staff A stated that she did not contact 911 because the resident asked her not to call. She said when her daughter (staff A's daughter) came to the facility, her daughter called 911.

On / at 2:35 PM, in an interview with the Agency for Health Care Administrator (AHCA) Central Office staff, the staff stated that the facility did not file the adverse incident report to their office as required.

Class III

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Z815 Background Screening: Prohibited Offenses

Based on record review and interviews, the facility failed to ensure that 1 of 3 staff had maintained a level 2 background screening prior to having resident contact (staff C).

Findings:

On / , review of staff C's employee file indicated that the last Level 2 background screening was completed on . . . . . Staff C's employment file did not reveal any updates since that date.

In an interview on / at 9 AM, the administrator was asked if the facility had completed the updated Level 2 background screen for staff C and stated, "No".

On , review of the Agency for Health Care Administration (AHCA) background screening web site did not reveal a Level 2 background screen for staff C.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Christie's Place Assisted Living Facility
471 Almansa Street
Palm Bay, Florida 32907

Attention: Marie Lourdes Philippe

Dear . Philippe,

This letter reports the findings of a complaint investigation (CCR 2015010659) conducted from to by a representative of the Agency for Health Care Administration. You are directed to comply with the tangible steps outlined below in order to correct the deficient practices. Attached are the deficiencies noted in the investigation.

The investigation resulted in findings of noncompliance with the following areas:

A025- Resident Care- Supervision- Class II- Your Assisted Living Facility failed to maintain to document a written record of significant changes that required medical attention, failed to complete assigned task on the Agency for Health Care Administration 1823 Health Assessment, left residents alone in the facility without staff supervision on multiple occasions and did not follow facility policy regarding .

A077- Staffing Standards-Administrators- Class II- Your Assisted Living Facility failed to ensure the facility provided a safe living environment by leaving residents unsupervised, residents, maintaining an inaccurate admission and discharge log, not reporting an adverse incident, allowing untrained staff to work with residents and allowing undocumented staff to work with residents.

Your facility must comply with the following:

1-Your facility must have a complete record of each resident of the facility, including a current and complete Agency for Health Care Administration (AHCA) 1823 health assessment. Current AHCA 1823 health assessments must be reviewed and ensured that all missing information is completed including: documentation of hospitalizations and documentation of significant changes in behavior and medical conditions.

2-All staff including the administrator are required to participate in retraining regarding resident rights and recognizing and reporting , neglect and . The training must be taught by a staff member from the Florida Department of Children and Families, Department of Elder Affairs or Ombudsman Office.
3-Staff schedules must be posted for review and the schedule must accurately reflect who is working each scheduled shift.
Under no circumstances should any resident be left alone without staff supervision.
This task must be completed immediately.

4-All staff providing care to residents must have current Level 2 background screens, current documentation indicating freedom from ( ) and documentation of completion of all required trainings. Staff assisting with medication must have the required training and updates and one staff person with current proof of training in First Aid and ( ) must be on duty in the building at all times.

5- The facility must have an administrator that is current with CORE training. The current administrator must retake CORE and pass the exam before serving as administrator.

All tasks must be completed by / .

Please be advised that nothing in this Directed Plan of Correction limits that Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Laura Manville, Assisted Living Facility Enforcement Team Manager at 727-552-1955 or Lorraine Henry, Assisted Living Facility Supervisor at 407-245-2502.

Sincerely

Theresa DeCanio, RN
Field Office Manager
LH/be

D7JR

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Christie's Place Assisted Living Facility
471 Almansa Street NE
Palm Bay, FL 32907

RE: CCR #2015010659

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation 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 , 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 -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure XG90

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