STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968482 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING ANGELS ASSISTED LIVING INC	9 RAMBLE WAY PALM COAST, FL 32164

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Robert Dobson	DATE 2-8-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 6/25/2015		☑ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☑ YES ☐ NO		

 EVENT ID: PGY013

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11968482	R
NAME OF PROVIDER OR SUPPLIER **LOVING ANGELS ASSISTED LIVING INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **9 RAMBLE WAY** **PALM COAST, FL 32164**	

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

0000 Initial Comments

A second follow-up visit to the biennial survey, in conjunction with a complaint survey (CCR # 2015011802) was conducted at Loving Angels Assisted Living Facility on . Loving Angels had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on resident record reviews, and interview with the Administrator, the facility failed to obtain complete information on the AHCA form 1823 (resident health assessment) for 2 of 3 residents whose assessments were reviewed (Resident #2).

The findings included:

Record review for Resident #2 found a resident health assessment dated / . On the front page of the assessment, the section asking what nursing or service requirements the resident had, it was left blank. The physician signed and dated the assessment; however, failed to write his address in the appropriate space on the signature page.

An interview was conducted with the Administrator at 12:25 pm on / . She acknowledged the omissions on Resident #2's health assessment, and stated she would have it corrected.

This was previously cited at the biennial licensure survey conducted by a representative of this office on , and recited after the follow-up survey conducted on / .

Class III

0053 Medication - Administration

Based on observation, resident record review, and interviews with staff, the facility failed to provide a licensed staff member to administer medications to 1 of 3 sampled residents reviewed for medications (Resident # 6).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11968482	R
NAME OF PROVIDER OR SUPPLIER **LOVING ANGELS ASSISTED LIVING INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **9 RAMBLE WAY** **PALM COAST, FL 32164**	

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

The findings included:

Observation of Resident #6 at 9:20 am on found her lying in a hospital bed, with her eyes closed and mouth open. She did not respond to my knock on the door, or my presence. This resident remained in her bed throughout the duration of the survey, remaining in bed to be fed her lunch meal.

An interview with employee BB (Caregiver and Medication Technician) was conducted at 11:35 am on . He stated Resident #6 was on hospice, and could no longer assist with self-administration of medication. He stated he, and the other medication technicians, had to place the resident's medications directly into her mouth.

Resident #6's record contained a resident health assessment dated / / . Page 4 of the assessment noted the resident required assistance with the self-administration of medications, as opposed to requiring her medication to be administered. The record also confirmed Resident #6 was under the care of hospice as of / . The hospice provider had identified Goals and Intervention on / for difficulty/inability to feed herself. The instructions directed caregivers in appropriate feeding strategies including reminding the patient to swallow.

An interview with Administrator at 11:40 am on confirmed Resident #6 had a recent, rapid decline, and was placed under the care of hospice. She confirmed the regulatory requirement for a licensed staff member to administer medications to Resident #6. She stated she would call the hospice provider to seek assistance.
Class III

0054 Medication - Records

Based on observation, a review of resident records, and interview with the Administrator, the facility failed to maintain complete medication observation records (MORs) that contained the name of the resident ' s health care provider, the health care provider ' s telephone number, and any the resident may have for 3 of 3 residents whose medications were reviewed (Residents #2, #6 and #7).

The findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11968482	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING ANGELS ASSISTED LIVING INC	9 RAMBLE WAY PALM COAST, FL 32164

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

1. A medication reconciliation review conducted for Residents #2, #6 and #7 found that the MORs for all three were missing the name, address and telephone number of the health care provider, and did not include any the resident(s) might have.

An interview with the Administrator was conducted at 11:15 am on / / . She reviewed the MOR and cofirmed the pharmacy omitted the required information.

This was previously cited at the biennial licensure survey conducted by a representative of this office on / , and recited after the follow-up survey conducted on / .

Class III

0077 Staffing Standards - Administrators

Based on resident and employee record reviews, and interview with staff, the Administrator failed to exercise supervision over the operation of the facility and the provision of care to the residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter.

The findings included:

Record reviews for Residents #2, #6 and #7, and review of personnel files for Employees BB and DD found the Administrator failed to correct deficiencies identified in the biennial licensure survey conducted on / / by a representative of this office, and at the follow-up survey conducted on / / . In addition, additional deficient practice was identified.

Cross Reference A0008, A0053, A0054, A0081, A0083, A0161, and Z816.

Unclassified

0081 Training - Staff In-Service

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968482	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING ANGELS ASSISTED LIVING INC	**9 RAMBLE WAY PALM COAST, FL 32164**

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

Based on a review of personnel files, and interview with the Administrator, the facility failed to arrange for the required in-service training in emergency preparedness and evacuations, recognizing/reporting , neglect and , and incident reporting for 1 of 4 sampled employees (Employee DD) whose files were reviewed.

The findings included:

A personnel file review conducted for Employee DD revealed she was hired / as a Caregiver. Further review of the file found no documentation of the required one-hour training within 30 days of hire in the facility's emergency procedures including chain-of-command, incident reporting, or in , neglect and .

An interview was conducted with the Administrator at 11:25 am on . She reviewed the file for Employee DD and stated she thought this employee's home health training had covered these issues. She confirmed the missing trainings for Employee DD.

This was previously cited at the biennial licensure survey conducted by a representative of this office on , and recited after the follow-up survey conducted on / .

Class III

0083 Training - First Aid and

Based on observation, a review of personnel files, and interview with staff, the facility failed to ensure certification in ( ) for 1 of 4 sampled employees (Employee BB) who was left in sole charge of the residents.

The findings included:

Upon entrance to the facility at 8:35 am on / , Employee BB was observed alone with the five residents who resided in the home. All residents but one were out of bed, and in the process of having

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968482	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING ANGELS ASSISTED LIVING INC	**9 RAMBLE WAY PALM COAST, FL 32164**

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

breakfast.

A personnel file review conducted for Employee BB revealed he began working in the facility as a Caregiver and Medication Technician on [illegible]. Further review of the file found Employee BB attended an online [illegible] training; however, the card issued by the provider contained no signatures. Online training requires an in-person skills demonstration and assessment of the employee by a certified trainer, as well as two signatures on the back of the card, upon completion of the class. In addition, the card was issued by an unapproved provider

An interview with Employee BB at 9:30 am on [illegible] confirmed he had taken an on line [illegible] class. He confirmed he never completed a face-to-face skills demonstration in front of a certified trainer. He was not aware this was not an accredited provider. An interview with Administrator at this same time confirmed the findings. He acknowledge Employee BB worked alone this morning without proper certification.

Class III

0161 Records - Staff

Based on a review of employee records, and interviews with staff, the facility failed to maintain personnel records that contained timely verification of level 2 background screening and compliance with all training requrements for 2 of 4 sampled employees (Employees BB and DD).

The findings included:

1. A personnel file review conducted for Employee DD revealed she was hired [illegible] as a Caregiver. Further review of the file found no documentation of the required one-hour training within 30 days of hire in the facility's emergency procedures including chain-of-command, incident reporting, or in [illegible], neglect and [illegible].

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) DATE SURVEY COMPLETED
	AL11968482	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING ANGELS ASSISTED LIVING INC	**9 RAMBLE WAY PALM COAST, FL 32164**

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

An interview was conducted with the Administrator at 11:25 am on . She reviewed the file for Employee DD and stated she thought this employee's home health training had covered these issues. She confirmed the missing trainings for Employee DD.

2. A personnel file review conducted for Employee BB revealed he began working in the facility as a Caregiver and Medication Technician on . Further review of the file found Employee BB attended an online training; however, the card issued by the provider contained no signatures. Online training requires an in-person skills demonstration and assessment of the employee by a certified trainer, as well as two signatures on the back of the card, upon completion of the class. In addition, the card was issued by an unapproved provider

An interview with Employee BB at 9:30 am on confirmed he had taken an on line class. He confirmed he never completed a face-to-face skills demonstration in front of a certified trainer. He was not aware this was not an accredited provider. An interview with Administrator at this same time confirmed the findings. He acknowledge Employee BB worked alone this morning without proper certification.

This was previously cited at the biennial licensure survey conducted by a representative of this office on , and recited after the follow-up survey conducted on .

Class III

Z816 Background Screening-Compliance Attestation

Based on a review of employee records, and interview with the Administrator, the facility failed to ensure that 1 of 1 potential employees (Employee DD) subject to level 2 background screening prior to employment had not had a break in service from a position that required level 2 screening for more than 90 days, out of a total of 4 employees reviewed for background clearance.

The findings included:

A personnel file review for Employee DD found she was hired as a caregiver on . Her application for employment revealed Employee DD worked as a home health and nurse's aid through 2015. It

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968482	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING ANGELS ASSISTED LIVING INC	**9 RAMBLE WAY PALM COAST, FL 32164**

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

did not list any other employment over the 5 1/2 months prior to her hire.

The level 2 background screening for Employee DD listed an eligibility date of / ; 2 1/2 months after hire. She was included in the background screening clearinghouse as a Homemaker/companion (a position that also required level 2 clearance) until . There was no employment captured by the clearinghouse after 2014.

Review of the facility staffing schedules confirmed Employee DD was scheduled, and working, in the facility since 2015.

An interview was conducted with the Administrator at 11:25 am on / . She was asked why the background screening for Employee DD was not obtained for 2 1/2 months after hire. The Administrator insisted Employee DD had a current level 2 upon hire, but was unable to produce proof. The Administrator produced the Affidavit of Compliance with Background Screening for Employee DD; however, it was dated / / ; also 2 1/2 months after hire.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Loving Angels Assisted Living, Inc.
9 Ramble Way
Palm Coast, FL 32164

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2016.

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 (904) 798-4201.

Sincerely,

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

LL/JM/sm
Enclosure

BBT7

Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone:(904) 798-4201; Fax:(904) 359-6054
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida