STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968676	R 02/02/2016
NAME OF PROVIDER OR SUPPLIER **ALL DUNN ASSISTANT LIVING, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **5726-28 LINCOLN STREET HOLLYWOOD, FL 33021**	

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

0000 Initial Comments

A follow-up visit to CCR 2015008463 survey was conducted at All Dunn Assistant Living, Inc. on 02/03/16. All Dunn Assistant Living, Inc. had uncorrected deficiencies at the time of the follow-up visit.

0051 Medication - Pill Organizers

Based on observation, interview, and record review, it was determined that the facility failed to use pill organizers only for residents who self-administer medications. Furthermore, the pill organizers used for storage and provision of resident medications were not filled or managed by a licensed nurse as required by Florida Administrative Code 58-A-5.0185(2).

The findings included:

During a 10:55 AM inspection of medication storage at the facility, the surveyor observed 3 pill organizers (also known as pill boxes) which were labeled with the names of Resident #2, Resident #3, and Resident #4.

Further observation and interviews revealed the following:

1) A multicolored pill organizer labeled with the name of Resident #2, containing 19 medication tablets was identified by the Administrator as containing medications prescribed for Resident #2.
The Administrator confirmed that she had removed the medications from the pharmacy labeled containers and placed them in the pill organizer. The Administrator confirmed that she is not a licensed nurse. The Administrator confirmed that the pill organizer was not labeled with the name. The Administrator was not able to accurately identify the medications stored in the pill organizer to the registered nurse surveyor. The Administrator was unable to explain how she identified the medications to Resident #2 during assistance with medications.

Photographic evidence was obtained.

2) A red pill organizer containing 19 medication tablets was identified by the Administrator as containing medications prescribed for Resident #3. The Administrator confirmed that she had removed the medications from the pharmacy labeled containers and placed them in the pill organizer. The Administrator confirmed that she is not a licensed nurse. The Administrator confirmed that the pill organizer was not labeled with the name. The Administrator was not able to accurately identify the

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medications stored in the pill organizer to the registered nurse surveyor. The Administrator was unable to explain how she identified the medications to Resident #2 during assistance with medications.

Photographic evidence was obtained.

3) A blue pill organizer containing 0 medication tablets was identified by the Administrator as being used to store medications prescribed for Resident #4.The Administrator stated " I put it in there before I give it. There ' s nothing in there " . The Administrator confirmed that the pill organizer was not labeled with the name.

Photographic evidence was obtained.

During a interview, the Administrator stated that she was unaware that she was prohibited from transferring the residents ' medications into pill organizers, and that she did not think it was an unsafe practice, as she had taken the medications from pharmacy labeled containers to place them in the pill organizers. The Administrator confirmed that she is not a licensed nurse or pharmacist. This was confirmed by review of the Florida Department of Health database of licensed health care providers.

During a 10:35 AM interview, Staff E stated that she had provided the morning medications to Residents #2, #3, and #4, and that the medications were not in pharmacy labeled containers when she had provided them to the residents.

A review of facility records confirmed that Residents #2, #3, and #4 each had multiple medications prescribed , and that each of these residents was to be provided assistance with self-medication. None of the named residents were assessed by their health care provider as appropriate to self-administer medications.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation, interview, and record review, it was determined that the facility failed to ensure

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that a staff member providing assistance with self-administration of medications (Staff E) had been provided the required training.

The findings included:

During a 10:35 AM interview, Staff E was asked whether residents had been provided morning medications. Staff E stated that the she had provided the medications to three residents later identified as Residents #2, #3, and #4.

Staff E was asked whether she was a medication assistant, to which she replied " No. What is that? "Staff E stated that she had not identified the medications to the residents, and that the medications were not in the pharmacy labeled containers when she provided them to Residents #2, #3, and #4.

A subsequent review of facility Medication Observation Records revealed the following:

1) Resident #2 was scheduled to receive 100 mg. (milligrams) at 9:00 AM, 500 mg. at 9:00 AM, 50 mg. at 9:00 AM, 50 mg at 9:00 AM, 5 mg at 9:00 AM, and 2.5 mg at 9:00 AM.

2) Resident #3 was scheduled to receive 500 mg. at 9:00 AM, 160 mg. at 9:00 AM, and 40 mg. at 9:00 AM.

3) Resident #4 was scheduled to receive Metroprolol 50 mg. at 8:00 AM, 10 mg. at 8:00 AM, 25 micrograms at 7:00 AM, 2.5 mg. at 8:00 AM, and 125 micrograms at 8:00 AM.

During a 10:55 AM interview, the facility Administrator stated that she had " handed her (Staff E) the medication to give to the residents " . The Administrator confirmed that Staff E had not been provided the required 4 hour training in assistance with self-medication.
The Administrator stated that she did not think Staff E had acted as a medication assistant because Staff E had " just handed them to them " . When asked how often Staff E provided assistance with self-administration of medications, the Administrator stated that a staff member had resigned earlier in the week and left the Administrator " in a dilemma " .

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A subsequent 2/3/16 review of the facility ' s employee files revealed that Staff E ' s personnel record contained no documentation of Staff E having received the required 4 hour training before providing assistance with self-administration of medications to residents.

Class III

0054 Medication - Records

Based on interviews and record review, it was determined that the facility failed to immediately update the Medication Observation Record (MOR) after providing assistance with self-administration of medications to residents. On / , residents #2, #3, and #4 were assisted with self-administration of medications, but the medications were not charted as provided on the residents ' MORs.

The findings included:

During a 10:35 AM review of facility MORs, the surveyor noted that the 7:00 AM, 8:00 AM, and 9:00 AM medications for that date had not been charted as provided for Resident#2, Resident #3, or Resident #4. The staff on duty, Staff E, stated that the residents had been provided the medications earlier that morning, but they had not been recorded as provided on the MORs.

The review of facility Medication Observation Records revealed the following:

1) Resident #2 was scheduled to receive 100 mg. (milligrams) at 9:00 AM, 500 mg. at 9:00 AM, 50 mg. at 9:00 AM, 50 mg at 9:00 AM, 5 mg at 9:00 AM, and 2.5 mg at 9:00 AM. None of the above medications had been charted as provided as of 10:35 AM on / .

2) Resident #3 was scheduled to receive 500 mg. at 9:00 AM, 160 mg. at 9:00 AM, and 40 mg. at 9:00 AM. None of the above medications had been charted as provided as of 10:35 AM on .

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3) Resident #4 was scheduled to receive Metroprolol 50 mg. at 8:00 AM, 10 mg. at 8:00 AM, 25 micrograms at 7:00 AM, 2.5 mg. at 8:00 AM, and 125 micrograms at 8:00 AM. None of the above medications had been charted as provided as of 10:35 AM on

During a 10:55 AM interview with the facility Administrator, The Administrator confirmed that Resident #2, Resident #3, and Resident #4 had been provided morning medications as ordered on , and that as of 10:55 AM, the medications had not been charted as provided in the residents ' Medication Observation Records.

Photographic evidence was obtained.

Class III

0082 Training - /

Based on observation, interview, and record review it was determined that the facility failed to ensure that all facility employees had completed the required education course on the /Acquired (/) within 30 days of employment, for 1 of 3 employees reviewed for training (Staff E) .

The findings included:

Upon entering the facility on at 10:15 AM, the surveyor observed one staff member, Staff E, to be present in the facility. Staff E confirmed that she was the only staff member present in the facility, and that she was currently responsible for the care and supervision of the 5 residents living at the facility.

During a 1:00 PM review of facility employee files, it was revealed that Staff E had no documentation of having received the mandatory / education course. Further review of Staff E ' s employee file revealed that she had been employed at the facility since / .
Staff E confirmed that she had not yet received the required / training despite being employed by the facility more than 1 year earlier.

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During a 1:30 PM interview, the facility Administrator admitted that Staff E did not have documentation of receiving / training within 30 days of employment because the training had not occurred.The Administrator stated that Staff E had been out of the country for several months since being employed, and that she (the Administrator) had not gotten around to providing all of the required trainings for Staff E.

Class

0083 Training - First Aid and

Based on observation, interview, and record review, it was determined that the facility failed to ensure that a staff member with current training in First Aid and ( ) was in the facility at all times.

The findings included:

Upon entering the facility on at 10:15 AM, the surveyor observed 1 staff member (staff E) to be present in the facility. Staff E confirmed that she was the only staff present in the facility.
Upon touring the facility accompanied by Staff E, the surveyor observed that there were 5 residents present in the facility.

During a 1:00 PM review of Staff E ' s personnel file, it was noted that Staff E had no documentation of a valid card documenting completion of First Aid or courses. Staff E confirmed that she did not have current or First Aid training.

During a 1:30 PM interview, the facility Administrator confirmed that there had been no staff with current First Aid or training in the facility when the surveyor had arrived at 10:15 AM. The Administrator stated that she had left Staff E alone in the building while she had gone to the pharmacy to fill a prescription for a resident. The Administrator stated that an employee had unexpectedly resigned and left her " in a dilemma " . The Administrator further stated that Staff E had been out of the country for several months since being hired in , 2015 so she had not " gotten around to " assuring that Staff E completed her required trainings.

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Class III

0161 Records - Staff

Based on record reviews and interviews, it was determined that the facility failed to provide documentation of compliance with required trainings for 1 of 3 staff personnel files (Staff E) reviewed.

The findings included:

Upon entering the facility at 10:15 AM on , the surveyor observed Staff E to be the only staff in the facility. Staff E confirmed that she was the only staff in the facility, and that she was currently providing direct care and supervision for the 5 residents of the facility. A brief tour of the facility revealed that there was 1 resident in the shower, 2 residents sleeping in bed, and 2 residents seated in a common area watching television.

During a review of facility personnel records, it was revealed that Staff E, whose date of hire was / , had no documentation of the following required trainings in her personnel file:

a)Infection control Training
b) - 2 hour training within 30 days of employment
c) Elopement Response - 1 hour training within 30 days of employment
d) Emergency Preparedness and Evacuation- 1 hour training within 30 days of employment
e) Incident Reporting- 1 hour training within 30 days of employment
f) Resident Rights- 1 hour training within 30 days of employment
g) Resident , Neglect, and - 1 hour of training within 30 days of employment
h) ( ) Policy and Procedures- 1 hour training within 30 days of employment

During a 1:00 PM interview, Staff E confirmed that the aforementioned trainings had not been completed. Staff E asked the surveyor to repeat the required trainings to her so that she could write them down and make sure that they were completed and documented in her personnel file.

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During a 1:30 PM interview with the facility Administrator, the Agency Field Office Assisted Living Supervisor participated in the interview via telephone. The Supervisor asked the Administrator why she had not provided the trainings to Staff E that she is permitted, as a core trained administrator, to provide herself. The Administrator stated that Staff E had been out of the country for several months during the past year, and that she (the Administrator) had not gotten around to providing the required trainings.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
All Dunn Assistant Living, Inc.
5726-28 Lincoln Street
Hollywood, FL 33021

Dear Administrator:

This letter reports the findings of a Revisit Survey to a licensure complaint conducted on 2, 2016 by a representative of this office. Attached are the provider's copies of the State (5000-3547) Form and Revisit Report, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Mayo-Davis
Field Office Manager

AMD/dso
Enclosures: State forms 5000-3547 and Revisit report

YOSF

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