STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967228	02/17/2016
NAME OF PROVIDER OR SUPPLIER THORNTON GARDENS III	STREET ADDRESS, CITY, STATE, ZIP CODE 3119 FLORENE DRIVE ORLANDO, FL 32806	

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

0000 Initial Comments

Re-licensure survey was conducted on . Thornton Gardens III had deficiencies found at the time of the visit.

0056 Medication - Labeling and Orders

Based on observation, record review and interview the facility failed to obtain an accurate medication order for Resident #2.

Finding:

On at 11:45 a.m. Resident #2's observation of the medication pass was conducted. Staff B (caregiver) assisted the resident with self-administered medication of 25 milligram (mg). The label on the bottle of the medication indicated 25 mg tablet, take 1 tablet by mouth at lunch time as needed. When asked whether the resident had requested to have the medication, Staff B said that the resident had not asked for it. She stated that she was told to give the medication to the resident at noon daily. She then provided the medication observation record (MOR) that showed the instruction to give 1 tablet once daily at 12:00 noon.

A review of Resident #2's current health assessment (AHCA Form 1823) dated / showed a list of medications including (generic for) 25 mg. The column "Direction for use" was left blank. Further review of the AHCA Form 1823 indicated the resident needed assistance with medication administration.

On at 12:15 p.m. the administrator stated the label on the bottle was wrong. The resident had been taken the medication at noon since according to the order from the hospital. She stated that the resident did not need medication administration. She acknowledged that the AHCA 1823 was not accurate.

Class III

0078 Staffing Standards - Staff

Based on observation, record review and interview, the facility failed to obtain an annual statement of freedom from communicable including ( ) for 1 out of 2 staff (Staff B.)

Finding:

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

Staff B was observed providing personal care to all 3 residents in the facility on . Staff B's personnel record did not have an annual statement of freedom from communicable including . The last statement found in the record was dated / .

On at 3:30 p.m. the administrator acknowledged that she had not obtained the annual statement from Staff B's health care provider.

Class III

0081 Training - Staff In-Service

Based on record review and interview, the facility failed to ensure 1 out of 2 staff had received required in-service training within 30 days of employment (Staff C).

Finding:

A review of staffing schedule revealed Staff C was a care giver working from 7 a.m. to 7 a.m. (24-hour shift). She was hired on / . Staff C's personnel file did not have documentation showing that the staff had received the following required training:

1. A minimum of 1 hour in-service training that covers the subjects: Reporting major incidents, reporting adverse incidents, and facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation.
2. A minimum of 1 hour in-service training regarding Resident Rights in an assisted living facility; recognizing and reporting resident , neglect, and .
3. Three hours in-service training that covers Resident behavior and needs; providing assistance with the activities of daily living (ADL). Staff C was neither a nurse nor a certified nursing assistant (CNA) nor a home health aide who would be exempt from this required training.

On at 3:35 p.m. the administrator stated that she had not kept Staff C's certifications in her personnel file at this location.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER **THORNTON GARDENS III**	STREET ADDRESS, CITY, STATE, ZIP CODE **3119 FLORENE DRIVE** **ORLANDO, FL 32806**	

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

Based on observation, record review and interview, the facility failed to ensure 2 out of 2 staff had received the required training on providing assistance with self-administered medication and safe medication practices in an assisted living facility (B and C).

Finding:

1. On at 11:45 a.m. Staff B was observed assisting Resident #2 with self-administered medication. Staff B was hired on . The staffing schedule showed she worked from 7 a.m. to 7 p.m. (24-hour shift). A review of Staff B's personnel record showed no evidence that Staff B had received, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medication. The last 2-hour training was in 2014.

2. Staff C was hired on / . She was scheduled to work from 7 a.m. to 7 p.m. (24-hour shift) alternately with Staff B. Staff C's personnel record did not contain an initial 4-hour training on providing assistance with self-administered medication.

On at 3:30 p.m. the administrator stated that she had not kept both staff's certifications in their personnel files.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Thornton Gardens III
3119 Florene Drive
Orlando, FL 32806

RE: Relicensure survey

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2016 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 , 2016.** 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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