STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964324	02/22/2016
NAME OF PROVIDER OR SUPPLIER **HAMMOND HOUSE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **5301 MCKINLEY STREET** **HOLLYWOOD, FL 33021**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2015011784 & CCR# 2015012256 , was conducted on 2/10/2016, 2/12/2016, 2/15/2016, , and at The Hammond House. The facility had deficiencies at the time of the investigation.

0025 Resident Care - Supervision

Based on record review and interview, the facility failed to notify a resident's physician regarding a change in condition, for 1 out of 3 resident records reviewed (Resident # 2).

The findings include:

In an interview and observations of Resident # 2 on / , she stated she has high , and she has been feeling for the last 4 nights. Resident # 2 was observed alert and oriented to time, place and people. Resident # 2 stated her doctor came to visit her approximately 5 days ago. Resident # 2 stated she complained of feeling to several staff within the last 3 nights, but no one has done anything to help her.

On / at PM a record review of Resident # 2's file found and admission date of . Resident # 2's Agency for Health Care form 1823 assessment is dated for / with the following diagnosis of: , , , , , , , , Restless Legs, , , and . Further review of Resident # 2's file found a physician evaluation of Resident # 2 and a physician's order dated for for home health services to monitor daily for 7 days and report to physician's office for a diagnosis of for Resident # 2.

On at 1:45pm an interview with Resident # 2 confirmed that she has not been receiving services from a third party provider since . Resident # 2 stated no one has checked her , since she saw her physician on .

On / in an interview with the Administrator at PM, he stated he thought it was Resident # 2's physician's responsibility to coordinate services for home health care. During the interview, the administrator acknowledged the error of the facility's failure to make arrangements for third party services for Resident # 2's care and services ordered by her physician.

Class III

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0052 Medication - Assistance with Self-Admin

Based on observation and interview, the facility failed to follow the proper procedures for providing assistance with self -administration of medication, for 1 out of 4 residents (Resident #1) observed during medication pass.

The findings include:

Observations on at 12:15 PM found Resident # 1 receiving the following medication: Sucralfate 1 gm that is documented on the medication observation record (MOR) as scheduled for 2 PM.

At 12:15 PM, observations during assistance with self- administration of medication revealed Staff B, a Home Health Aide (HHA), assisted Resident # 1 with self - administration of medication. Staff B did not sanitize her hands, unlocked the medication cabinet, obtained the packet of medication, walked away from the unlocked and unsecured medication cabinet, put Resident # 1's medication in a cup, and gave the medication along with a cup of water to the resident. Staff B did not state the name of the medication to Resident # 1. Staff B did not observe Resident # 1 swallow the medication and signed Resident # 1's Medication Observation Record (MOR) one date ahead as being assisted with the medication dated for / at 8 AM.

During an interview on at 12:25 PM, Staff B was informed of the process for assisting residents with self- administration of medications. Staff B acknowledge that Resident #1 was provided the medication before the 1 hour window of the medication dosage time; medication due at 2 PM provided at 12:15 PM. The Administrator and Staff B acknowledged the errors found during assistance with self- administration of medications.

Class III

0054 Medication - Records

Based on interview, observations and record review, the facility failed to update the Medication Observation Record (MOR) and document correct dates after a medication is offered, for 2 out of 4 residents (Resident # 1 and Resident # 4) medication records reviewed.

The findings include:

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A record review of Resident # 1's MOR for the month 2016 on 2/10/2016 found Resident # 1 receiving the following medications.
a) 25 mg at 8 AM
b) Sucralfate 1 gm at 8 AM
c) 2 PM, and 8 PM
d) 1 mg at 8 AM
e) 12 PM, 4 PM, and 8 PM
f) 10 mg at 8 AM, PM, and 8 PM
g) 15 ml at 8 AM, 2 PM and 8 PM

On / at 12:15 PM, a record review of Resident # 1's MOR found a staff members' signature documented one day in advance for the medication Sucralfate 1 gm scheduled for 2 PM that indicates the medication was taken at 12:15 PM during assistance with self administration of medications dated for / . Copy of MOR obtained. Further record review of Resident # 1's MORs found her medication 1 mg was given to her at 8 AM and revealed a staff member's signature documented for assisting Resident # 1 at 8 AM and 12 PM. On / at 12:15 PM during assistance with self administration of medication, observations revealed Resident # 1 did not receive the 1 mg scheduled for 12 PM. Resident # 1's MORs revealed no staff members' signatures documenting that Resident # 1 received the following medications: 25 mg at 8 AM on , 10 mg at 8 AM on , and 15 ml at 2 PM from through and from through scheduled at the following times: 8 AM, 2 PM, and 8 PM. (Copies of MORs obtained as evidence).

A record review of Resident # 4's MOR for the month 2016 on / at 12:15 PM found Resident # 4 receiving the following medication: HBR 10 mg daily at 8 AM. Resident # 4's MORs revealed no staff members' signature documenting that Resident #4 received the medication HBR 10 mg at 8 AM.

During an interview on / at 12:30 PM , Staff A, Staff B and the Administrator was informed of the error found on Resident # 1's and Resident # 4's MOR. At 12:35 PM, the Administrator acknowledged the findings.

Class III

0055 Medication - Storage and Disposal

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Based on observation, interview, and record review, it was determined that the facility did not dispose a resident's medications within 30 days after the resident was discharged from the facility for 2 out of 6 residents (Resident # 5 and Resident # 6) during observation of the facility's medication storage. The findings include:
During an observation of the medication storage on / at 10:30 AM with Staff A and Staff B present, the inside of the medication cabinet contained a plastic bin of multiple medications prescribed for pain, , and anti- labeled for Resident # 5 who was discharged from the facility since / / and two bottles of liquid labeled for Resident # 6 who has been discharged from the facility since . (Photographic evidence obtained)
In an interview on at 12 PM with the Administrator, he stated he was holding Resident # 5's medications because he was still waiting on someone to pick up the medications. The Administrator further stated he was unaware if the pharmacy was suppose to pick up Resident # 5's medications or if the medications should have been disposed. During the interview with the Administrator, he was questioned about Resident # 6's liquid medication for found in the facility's medication cabinet and he had no response. An interview with the Administrator revealed Resident # 5 was discharged from the facility to a skilled nursing facility on / / due to a requirement of a higher level of care and Resident # 6 was discharged from the facility on per family request due to requirement of a tube.

In an interview with the Administrator on / at 1 PM, inappropriate storage of medication was acknowledged and discussed.

Class III

0079 Staffing Standards - Levels

Based on record review and interview, the assisted living facility failed to maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period.

The Findings Include:

On / at 9:30 AM, observations during a tour of the facility found two employees providing direct care to residents. In an interview with Employee B on at approximately 9:45 AM, she stated that she works a 24 hour work shift from 2 PM through 2 PM the following day two times a week. In an interview with Employee A, she stated she works a 24 hour shift from 2 PM - PM twice a week and is also on call when she is not on schedule to assist with office work. During the interviews on /

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Employee A and Employee B stated the Administrator comes to the facility once a week.

On 2/10/2016, a record review of the facility's staffing schedule found no written work schedule which reflects times worked by each employee listed on the monthly schedule.

In an interview with the Administrator on / at approximately 1 PM, he stated he is at the facility everyday. He stated when he is not present in the facility, Employee A is in charge. On , a record review of Employee A's file found no job description as the designated ALF Manager. Employee A's file found a recent job description as a certified nurse assistant (CNA). In an anonymous interview with a resident and other staff members employed by the facility, it was revealed that the Administrator comes to the facility one a week.

During the interview, the Administrator had no response when questioned "who is designated as the ALF manager when the Administrator is absent." The Administrator acknowledged that the posted staffing schedule does not reflect the current work time schedules and .

Class III

0084 Trainina - Assis Self-Admin Meds & Med Mamt

Based on record review and interview, the facility failed to ensure that 2 out of 4 staff members (Staff A and C) received the initial 4 hour and annual 2 hour training update on Assistance with Self-Administered Medication and Medication Management.

The Findings Include:

In an interview with Staff A on , she stated that she assists the residents in the facility with self-administration of medications. A record review of the Staff A's personnel file on revealed a hire date of 2015 as a Certified Nurse Assistant. Further review of Staff A's file found her last annual 2 hour training update on Assistance with Self-Administered Medication and Medication Management was completed on . Record review found no documentation of an initial 4 hours of training on assistance with self-administered medication and medication management.

In an interview with Staff C on / she stated that she assists the residents in the facility with self-administration of medications. A record review of the Staff C's personnel file on revealed a hire date of 2012 as a Home Health Aide. Further review of Staff C's file found her last annual 2 hour

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training update on Assistance with Self-Administered Medication and Medication Management was completed on 5/23/2014 and her initial 4 hours of training completed on . Record review found no documentation of an annual 2 hours of training on assistance with self-administered medication and medication management since .

In an interview conducted on at 2 PM, the Administrator acknowledged the findings and stated no further information was available for review.

Class III

0160 Records - Facility

Based on record review, observation and interview, the facility failed to ensure 2 out of 5 residents discharged from the facility (Resident # 5 and Resident # 6) had documented dates of discharge, reason for discharge, and identification of the facility or home address to which the residents was discharged.

The findings include:

On , observations of the facility's medication storage revealed two containers of medications for Resident # 5 and Resident # 6 who no longer reside in the facility. On , interviews with Staff A and Staff B revealed Resident # 5 was discharged approximately 3 months ago and Resident # 6 was discharged from the facility in the month of 2015. Staff A and Staff B stated they could not recall Resident # 5's and Resident # 6's exact dates of discharge.

On , a record review of the facility's census revealed 4 residents residing in the facility and one resident pending admission to the facility from a hospital. A record review of the facility's Admission and Discharge Logs revealed Resident # 5's admission date of / / and Resident # 6's date of admission of . The facility's Admission and Discharge Logs found no documentation of Resident # 5's and Resident # 6's date, location, and reason for discharge.

In an interview with Administrator on , he stated Resident # 5 was discharged to a skilled nursing facility on / / because Resident # 5 required a higher level of care. On the Administrator stated Resident # 6 was discharged home in 2015 with a relative because Resident # 6 required a tube.

On at approximately 2 PM, the Administrator acknowledged the failure of not maintaining an up- to- date Admission and Discharge log.

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Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Hammond House (The)
5301 McKinley Street
Hollywood, FL 33021

RE: CCR #2015012256 & #2015011784

Dear Administrator:

This letter reports the findings of a State Licensure Survey that was conducted on , 2016 by a representative from 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 17, 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

XG90

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