STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943141	03/01/2016
NAME OF PROVIDER OR SUPPLIER **ELZAIDA'S TENDER CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **804 SOUTH BELCHER ROAD** **CLEARWATER, FL 33764**	

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

0000 Initial Comments

Assisted Living Facility

Amended

A complaint survey (CCR# 2016001818) was conducted at Elzaida's Tender Care from through . Elzaida's Tender Care, Assisted Living Facility, had deficiencies at the time of the visit. Please be advised that the text for Tag A 058 was administratively changed on .

0030 Resident Care - Rights & Facility Procedures

Based on interview, record review, and observation, the facility failed to provide a safe and decent living environment for 5 out of 5 (Residents 1-5) residents.

Findings included:

On at 10:15 AM the facility temperature registered as 82 degrees. The air conditioner was in the off position. All of the windows in the home were closed, and no indoor fans were running.
On at 10:20 AM an observation was made of the pantry in the facility. Multiple cans of expired food were identified in the pantry.
On at 10:20 AM an observation was conducted of # in the facility. The a strong odor. The no toilet paper, no soap, and no paper towels. A pile of used adult diapers was observed in the corner of the . There was no trash can observed in the .
On at 10:20 AM an observation was conducted of # in the facility. The no soap or paper towels. There was a black substance in the shower, confirmed during the survey by a Department of Health Inspector, to be mold. The ceiling was patched and peeling. The ceiling fan was uncovered; the blades appeared rusted and covered with cobwebs.
On at 11:31 AM an observation was conducted of the owner as she prepared lunch. The owner came from her private began to prepare lunch. The owner did not wash her hands prior to using her bare hands to hold and cut lettuce and tomatoes for a salad.
On at 12:25 PM an interview was conducted with the Environmental ( ) from the Department of Health (DOH). The stated she was at the facility to conduct an inspection. The stated the facility was required to provide toilet paper, soap, paper towels, and a trash can in all . The stated # had mold and the facility would be cited. The stated the owner was observed preparing food without washing her hands and would be cited. The DOH stated the facility failed the inspection.
On at 1:24 PM an interview was conducted with Resident #1. Resident #1 stated she is

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yelled at if she attempts to touch the thermostat. Resident #1 stated she is normally hot in the facility. Resident #1 stated the owner the fan in her that she could not run it continuously. Resident #1 stated she is expected to clean # , and she has to purchase cleaning supplies for the of her own money. Resident #1 stated the owner does not clean the facility.
On at 1:34 PM an interview was conducted with Resident #4. Resident #4 stated it is " normally hot in here. Gets really hot in here. " Resident #4 stated she requires an machine while in the facility, and uses a portable tank when she leaves the facility. Resident #4 stated the facility does not provide transportation, so she had to walk to the grocery store with her portable to pick up food, toilet paper, and soap. Resident #4 stated she informed the owner about her food when she moved in, and provided the owner with a list. The owner told her it would best be handled by Resident #4 buying and cooking her own food. Resident #4 stated she was to the vegetables the owner served mixed in with the casserole at today ' s lunch.
On at 1:45 PM an interview was conducted with Resident #5. Resident #5 stated they have to clean the their own. Resident #5 stated when she moved in " the a mess. " Resident #5 stated she has to clean # . She stated in regards to the owner cleaning the : " She ' s elderly. It ' s all she can do to go to the kitchen to make meals. She rests a lot. " Resident #5 stated they are not provided with snacks. " We only pay $1000. She told us we can ' t expect snacks for that amount. " Resident #5 indicated she was told by the owner that most residents have to pay $2,000-3,000 per month to stay in an assisted living facility.
On at 2:10 PM an interview was conducted with the owner. The owner stated the contract states she will not provide toilet paper. The owner stated the residents all receive a personal needs allowance, and can purchase soap and paper towels with that money. The owner stated she does not clean and the residents are told to clean up after themselves in the . The owner denied any of the residents had complained about the facility being hot. The owner stated it is not hot in the facility.

Class III

0052 Medication - Assistance with Self-Admin

Based on interview, observation, and record review, the facility failed to observe 1 out of 5 (Resident #1) sampled residents who requires assistance with medications, take the prescribed medication as required under 429.256 F.S.; the facility failed to notify the primary care physician ' s office when medications were stolen, or when the 1 out of 5 (Resident #1) was non-compliant with medications; and the facility failed to keep an accurate record of when 2 out of 5 (Resident #1 and #2) received assistance with self-administration of medications.

Findings included:

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On at 2:22 PM a record review was conducted of Resident #1 ' s health assessment (AHCA form 1823). The 1823 was dated and identified that Resident #1 needed assistance with self-administration of medications.
On at 2:00 PM an interview was conducted with a Department of Children and Families (DCF) Adult Protective Investigator (API). The API stated Resident #1 is out of her medication, and had missed several doses prior to his visit on . The API expressed concern that the owner showed no interest or concern regarding the missing medication, and did not appear to understand the seriousness of the issue.
On at 12:59 PM an observation of Resident #1 ' s medication was conducted. The medications were stored in a locked cabinet in the kitchen. The resident had medications in two forms: bubble packs and the prefilled fast packs. The bubble packs contained the medications and . The fast pack medications were separated into 8:00 AM , D-3, and ; 12:00 PM ; and 5:00 PM , and . There were no medications for the evening of , or any medications for . The morning medications were missing for . The next medication was observed to be for 5:00 PM on .
On at 12:59 PM an interview was conducted with the owner. The owner stated Resident #1 would not take the medications in front of her. The owner stated Resident #1 " has a way of losing her medications " . The owner stated Resident #1 takes the medications with her to her , and then comes back and says she dropped them or lost them, and she asks for more. The owner stated she can ' t refuse to provide her with her medications, so she gives her additional medications. The owner stated that she was aware that she was required to watch the residents take their medications in front of her.
On at 12:59 PM in a continued interview with the owner, the owner stated Resident #6 stole the key to the medication cabinet and had taken the medication for Resident #1. The owner stated she thought Resident #1 had instructed Resident #6 to take the medication; therefore, the owner did not make any attempts to refill the medication. The owner stated the Resident #1 was searched, and the medication was not located. The owner stated Resident #6 is no longer in the facility. The owner stated she did not call the primary care physician ' s (PCP) office and report the lack of medication to the PCP. The owner stated she does not call the PCP ' s office and report noncompliance with medications.
On at 12:59 PM a record review was attempted. The owner could not locate the medication observation record (MOR) for Resident #1. The MOR was not located prior to the end of the survey.
On at 1:24 PM an interview was conducted with Resident #1. Resident #1 stated the medication that was stolen was for . Resident #1 stated she had not received her medication for five days. Resident #1 stated her searched as well as the facility, and the medication was not located. Resident #1 stated the owner had not made any effort to have the medication refilled or replaced. Resident #1 stated she called her physician ' s office and requested the owner speak with them, but the owner refused.
On at 1:35 PM a record review was conducted of the MOR sent to surveyor by the owner. A comparison was done of the MOR (MOR #2) sent by the owner and the MOR (MOR #1) emailed to

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ELZAIDA'S TENDER CARE	**804 SOUTH BELCHER ROAD CLEARWATER, FL 33764**

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(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

surveyor by the DCF API that he received during his investigation on . There were several discrepancies between the two. MOR #1 showed Resident #1 was to receive , three times daily. MOR #2 did not have listed. MOR #1 showed Resident #1 was to receive at 8:00 PM. MOR #2 showed Resident #1 was to receive (generic of) at 8:00 AM, 5:00 PM, and 8:00 PM. MOR #1 showed Resident #1 was not to receive Chlordiazepoxide, as it was discontinued. MOR #1 had not been signed for the month of . MOR #2 was signed for 8:00 AM and 5:00 PM from // through at the 8:00 AM dosage. MOR #1 showed , was discontinued. MOR #2 was signed as providing the medication from / through at 8:00 PM. MOR #1 showed is a PRN medication. MOR #1 was not signed at all for the month of . MOR #2 had hand written " 8pm " and was signed every night from / through . MOR #1 showed Resident #1 was not to receive the patch as it had been discontinued. MOR #2 was signed indicating Resident #1 had received the patch at 8:00 AM from // through .

On at 12:59 PM an interview was conducted with the owner. The owner stated she had assisted Resident #2 with medications at 12:00 PM.

On at 12:59 PM a record review was conducted of the MOR for Resident #2. The MOR had not been signed for the medications that had been provided at 12:00 PM.

On at 1:05 PM a continued interview was conducted with the Owner. The Owner stated she keeps the MOR in her /office, and she hands out the medications in the kitchen and then goes into her /office to sign the MOR. The owner stated she does not always do it immediately, and sometimes forgets for a while. The owner stated she had not yet had time to sign the MOR for the lunch medications, which had been provided an hour earlier. The owner stated she did not need to check the MOR as she was providing medications, because " I have been doing this for 16 years. I know I am giving the right medications. "

On at 7:13 PM a follow-up interview was conducted with the owner. The owner stated Resident #1 also receives a patch. The owner stated she continues to sign off on the MOR as providing the medication to Resident #1, however, Resident #1 refuses to allow the owner to assist with the patch and Resident #1 keeps the medication in her . The owner stated she signs the MOR when Resident #1 tells her she has used the patch. The owner stated Resident #1 receives Ensure four times a day, but she does not know if Resident #1 takes it, because Resident #1 keeps the Ensure in her .

On at 9:57 AM an interview was conducted with Resident #1 ' s primary care physician (PCP). The PCP stated Resident #1 " absolutely needs assistance " with the self-administration of medications. The PCP stated the , was discontinued on , and Librium was prescribed. The PCP stated Resident #1 is also prescribed (generic for) 400 mg at bedtime. The PCP stated the last request for refill was in .

Class II

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0054 Medication - Records

Based on interview and record review, the facility failed to immediately update the medication observation record (MOR) for 1 out of 5 (Resident #2) sampled residents each time the medication is offered or administered.

Findings included:

On at 12:59 PM an interview was conducted with the owner. The owner stated she had assisted Resident #2 with medications at 12:00 PM.
On at 12:59 PM a record review was conducted of the MOR for Resident #2. The MOR had not been signed for the medications that had been provided at 12:00 PM.
On at 1:05 PM a continued interview was conducted with the Owner. The Owner stated she keeps the MOR in her /office, and she hands out the medications in the kitchen and then goes into her /office to sign the MOR. The owner stated she does not always do it immediately, and sometimes forgets for a while. The owner stated she had not yet had time to sign the MOR for the lunch medications, which had been provided an hour earlier. The owner stated she did not need to check the MOR as she was providing medications, because " I have been doing this for 16 years. I know I am giving the right medications. "
On at 1:35 PM a record review was conducted of Resident #1 ' s MOR that was sent to surveyor by the owner. A comparison was done of the MOR (MOR #2) sent by the owner and the MOR (MOR #1) for Resident #1 emailed to surveyor by the DCF API that he received during his investigation on . There were several discrepancies between the two. MOR #1 showed Resident #1 was to receive three times daily. MOR #2 did not have listed. MOR #1 showed Resident #1 was to receive at 8:00 PM. MOR #2 showed Resident #1 was to receive (generic of) at 8:00 AM, 5:00 PM, and 8:00 PM. MOR #1 showed Resident #1 was not to receive Chlordiazepoxide, as it was discontinued. MOR #1 had not been signed for the month of . MOR #2 was signed for 8:00 AM and 5:00 PM from / through at the 8:00 AM dosage. MOR #1 showed was discontinued. MOR #2 was signed as providing the medication from / through at 8:00 PM. MOR #1 showed is a PRN medication. MOR #1 was not signed at all for the month of . MOR #2 had hand written " 8pm " and was signed every night from / through . MOR #1 showed Resident #1 was not to receive the patch as it had been discontinued. MOR #2 was signed indicating Resident #1 had received the patch at 8:00 AM from / through .
On at 9:57 AM an interview was conducted with Resident #1 ' s primary care physician (PCP). The PCP stated Resident #1 " absolutely needs assistance " with the self-administration of medications. The PCP stated the was discontinued on , and Librium was

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prescribed. The PCP stated Resident #1 is also prescribed (generic for) 400 mg at bedtime. The PCP stated the last request for refill was in .

Class III

0056 Medication - Labeling and Orders

Based on interview and record review the facility failed to provide doctor prescribed medications and failed to make attempts to refill a medication for 1 out of 5 (Resident #1) sampled residents.

Findings included:

On at 2:00 PM an interview was conducted with a Department of Children and Families (DCF) Adult Protective Investigator (API). The API stated Resident #1 is out of her medication, and had missed several doses prior to his visit on . The API expressed concern that the owner showed no interest or concern regarding the missing medication, and did not appear to understand the seriousness of the issue.
On at 12:59 PM an interview was conducted with the owner. The owner stated Resident #6 stole the key to the medication cabinet and had taken the medication for Resident #1. The owner stated she thought Resident #1 had instructed Resident #6 to take the medication; therefore, the owner did not make any attempts to refill the medication. The owner stated the Resident #1 was searched, and the medication was not located. The owner stated Resident #6 is no longer in the facility.
On at 12:59 PM a record review was attempted. The owner could not locate the medication observation record (MOR) for Resident #1. The MOR was not located prior to the end of the survey.
On at 1:24 PM an interview was conducted with Resident #1. Resident #1 stated the medication that was stolen was for . Resident #1 stated she had not received her medication for five days. Resident #1 stated her searched as well as the facility, and the medication was not located. Resident #1 stated the owner had not made any effort to have the medication refilled or replaced. Resident #1 stated she called her physician ' s office and requested the owner speak with them, but the owner refused.

Class III

0058 Pharmacy & Dietary: Uncorrected Deficiencies

Based on interview and record review, the facility received a Class II deficiency regarding the assistance with self-administration of medications. As a result of the Class II deficiency, the facility is required to employ a pharmacy consultant.

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Findings included:

The facility was cited for a Class II deficiency related to assistance with self administration of medication based on the following information. On at 2:22 PM a record review was conducted of Resident #1's health assessment (AHCA form 1823). The 1823 was dated and identified that Resident #1 needed assistance with self-administration of medications.
On at 2:00 PM an interview was conducted with a Department of Children and Families (DCF) Adult Protective Investigator (API). The API stated Resident #1 is out of her medication, and had missed several doses prior to his visit on . The API expressed concern that the owner showed no interest or concern regarding the missing medication, and did not appear to understand the seriousness of the issue.
On at 12:59 PM an observation of Resident #1 ' s medication was conducted. The medications were stored in a locked cabinet in the kitchen. The resident had medications in two forms: bubble packs and the prefilled fast packs. The bubble packs contained the medications and . The fast pack medications were separated into 8:00 AM , , D-3, and ; 12:00 PM ; and 5:00 PM , , and . There were no medications for the evening of , or any medications for . The morning medications were missing for . The next medication was observed to be for 5:00 PM on .
On at 12:59 PM an interview was conducted with the owner. The owner stated Resident #1 would not take the medications in front of her. The owner stated Resident #1 " has a way of losing her medications " . The owner stated Resident #1 takes the medications with her to her , and then comes back and says she dropped them or lost them, and she asks for more. The owner stated she can ' t refuse to provide her with her medications, so she gives her additional medications. The owner stated that she was aware that she was required to watch the residents take their medications in front of her.
On at 12:59 PM in a continued interview with the owner, the owner stated Resident #6 stole the key to the medication cabinet and had taken the medication for Resident #1. The owner stated she thought Resident #1 had instructed Resident #6 to take the medication; therefore, the owner did not make any attempts to refill the medication. The owner stated the Resident #1 was searched, and the medication was not located. The owner stated Resident #6 is no longer in the facility. The owner stated she did not call the primary care physician ' s (PCP) office and report the lack of medication to the PCP. The owner stated she does not call the PCP ' s office and report noncompliance with medications.
On at 12:59 PM a record review was attempted. The owner could not locate the medication observation record (MOR) for Resident #1. The MOR was not located prior to the end of the survey.
On at 1:24 PM an interview was conducted with Resident #1. Resident #1 stated the medication that was stolen was for . Resident #1 stated she had not received her medication for five days. Resident #1 stated her searched as well as the facility, and the medication was not located. Resident #1 stated the owner had not made any effort to have the medication refilled or

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replaced. Resident #1 stated she called her physician ' s office and requested the owner speak with them, but the owner refused.
On at 1:35 PM a record review was conducted of the MOR sent to surveyor by the owner. A comparison was done of the MOR (MOR #2) sent by the owner and the MOR (MOR #1) emailed to surveyor by the DCF API that he received during his investigation on . There were several discrepancies between the two. MOR #1 showed Resident #1 was to receive , three times daily. MOR #2 did not have listed. MOR #1 showed Resident #1 was to receive at 8:00 PM. MOR #2 showed Resident #1 was to receive (generic of) at 8:00 AM, 5:00 PM, and 8:00 PM. MOR #1 showed Resident #1 was not to receive Chlordiazepoxide, as it was discontinued. MOR #1 had not been signed for the month of . MOR #2 was signed for 8:00 AM and 5:00 PM from / through at the 8:00 AM dosage. MOR #1 showed , was discontinued. MOR #2 was signed as providing the medication from / through at 8:00 PM. MOR #1 showed is a PRN medication. MOR #1 was not signed at all for the month of . MOR #2 had hand written " 8pm " and was signed every night from / through . MOR #1 showed Resident #1 was not to receive the patch as it had been discontinued. MOR #2 was signed indicating Resident #1 had received the patch at 8:00 AM from / through .
On at 7:13 PM a follow-up interview was conducted with the owner. The owner stated Resident #1 also receives a patch. The owner stated she continues to sign off on the MOR as providing the medication to Resident #1, however, Resident #1 refuses to allow the owner to assist with the patch and Resident #1 keeps the medication in her . The owner stated she signs the MOR when Resident #1 tells her she has used the patch. The owner stated Resident #1 receives Ensure four times a day, but she does not know if Resident #1 takes it, because Resident #1 keeps the Ensure in her .
On at 9:57 AM an interview was conducted with Resident #1 ' s primary care physician (PCP). The PCP stated Resident #1 " absolutely needs assistance " with the self-administration of medications. The PCP stated the , was discontinued on , and Librium was prescribed. The PCP stated Resident #1 is also prescribed (generic for) 400 mg at bedtime. The PCP stated the last request for refill was in .
On at 12:59 PM a record review was conducted of the MOR for Resident #2. The MOR had not been signed for the medications that had been provided at 12:00 PM.
On at 12:59 PM an interview was conducted with the owner. The owner stated she had assisted Resident #2 with medications at 12:00 PM.
On at 1:05 PM a continued interview was conducted with the Owner. The Owner stated she keeps the MOR in her /office, and she hands out the medications in the kitchen and then goes into her /office to sign the MOR. The owner stated she does not always do it immediately, and sometimes forgets for a while. The owner stated she had not yet had time to sign the MOR for the lunch medications, which had been provided an hour earlier. The owner stated she did not need to check the

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MOR as she was providing medications, because " I have been doing this for 16 years. I know I am giving the right medications. "

Class III

0083 Training - First Aid and

Based on interview and record review, the facility failed to ensure 1 out of 2 (the owner) sampled staff who are left alone in the facility with residents have completed a course in First Aid and hold a current valid card documenting completion of such course.

Findings included:

On at 11:30 AM a record review was conducted for the employee file for the owner. No current valid First Aid card was located.
On at 12:21 PM an interview was conducted with the owner. The owner stated " It was in there. " The owner was unable to locate a valid First Aid card.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on interview and observation, the facility failed to provide a safe living environment for 5 out of 5 (Residents 1-5) residents in the facility.

Findings included:

On at 10:20 AM an observation was conducted of # in the facility. The no soap or paper towels. There was a black substance in the shower, confirmed during the survey by a Department of Health Inspector, to be mold. The ceiling was patched and peeling. The ceiling fan was uncovered; the blades appeared rusted and covered with cobwebs.
On at 12:25 PM an interview was conducted with the Environmental ( ) from the Department of Health (DOH). The stated she was at the facility to conduct an inspection. The stated # had mold and the facility would be cited.
On at 1:24 PM an interview was conducted with Resident #1. Resident #1 stated she was expected to clean # , and has had to purchase cleaning supplies with her own money. Resident #1 stated the owner does not clean the or the .
On at 1:45 PM an interview was conducted with Resident #5. Resident #5 stated she has to

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clean the [redacted] #[redacted] on her own. Resident #5 stated when she moved in " the [redacted] a mess. "

On [redacted] at 2:06 PM an interview was conducted with the owner. The owner stated she does not remember the last time the shower was cleaned. The owner stated she does not clean. The owner stated she told the residents they need to clean up after themselves so that the [redacted] ready for the next resident.

Class III

0160 Records - Facility

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

Findings included:

On [redacted] at 11:40 AM a record review was conducted of the facility's admission and discharge log. Seven residents were listed as being current residents in the facility. Resident #4 was not on the log. Resident #7 was listed as being admitted on [redacted], but was not listed as discharged. Resident #7 was not identified as one of the current residents in the facility.
On [redacted] at 12:36 PM an interview was conducted with the owner. The owner stated " I forgot to add her " about Resident #4. Resident #4 signed a contract on [redacted]. The owner stated Resident #7 " left a long time ago. I can't remember when she moved out. " The owner did not know her discharge date or location.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Elzaida's Tender Care
804 South Belcher Rd
Clearwater, FL 33764

Dear . McGarrity-Davis:

This letter reports the findings of a complaint survey and a revisit to a biennial state licensure survey conducted from - / , by representatives of the Agency for Health Care Administration. Attached are the provider's copies of the Statement of Deficiencies, which indicate there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's request as directives below:

The inspection resulted in findings of non-compliance in the following areas:

A 0052 – Medication – Assistance with Self-Admin – The facility failed to observe residents who require assistance with medications take the prescribed medication as required. The facility failed to notify the primary care physician's office when medications were stolen, or when a resident was non-compliant with medications; and the facility failed to keep an accurate record of when residents received assistance with self-administration of medications.

Z815 – Background Screening; Prohibited Offenses - The facility failed to ensure that all employees had a Level II background screening prior to having direct contact with residents.

You are directed to comply with the following requirements:

1). The facility must ensure all staff who provide services to the residents have a valid Level II background screening and have been found "eligible". This must be completed **immediately**.

2). The facility must obtain for the Administrator and all employees, the initial four-hour training in assistance with self-administration of medications. This must be completed by **, 2016.**

3). The facility must have an RN or pharmacist audit the medication cart. This must be completed by **, 2016.**

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . **Laura Manville**, Survey and Certification Support Branch, at (727) 552-1955 or **Paul Brown**, St. Petersburg Field Office, (727) 552-2000.

Sincerely,

Paul Brown
Health Facility Evaluator Supervisor