AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911288	03/29/2016
NAME OF PROVIDER OR SUPPLIER **BEGGS POINTE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **4711 BEGGS ROAD** **ORLANDO, FL 32810**	

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

0000 Initial Comments

The re-licensure survey was conducted on . Beggs Pointe ALF had deficiencies at the time of the visit.

0025 Resident Care - Supervision

Based on record review, Medication Observation Record (MOR) review and interview, the facility failed to provide Medications as Ordered by the Physician to 1 of 2 sampled residents (#2).

Findings:

Observations on at 9:45 AM, Resident #2 was observed in bed and was contracted. He was and was not able to talk.
On at 10 AM, Staff B stated Resident #2 received Hospice Services.
Observations on at 12:30 PM, Staff B was observed crushing medication and placing the medication in applesauce. Staff B took the medication to the fed it to Resident #2. Staff B said at the time Resident #2 could not take his own medication and staff had to feed it to him. Staff B said she was giving the resident the medication for drooling.
On at 12:35 PM Staff B was asked to provide the medication that she had just given Resident #2. A review of the Medication Package noted 0.125 mg every four hours for and . The MOR noted the same and was marked as given every day-4 times daily at 8AM, 12 PM, 5 PM and 8 PM.

Record review for Resident #2 revealed a Resident Health Assessment form 1823 dated and noted a diagnosis of Advance , the 1823 noted he was total Care with all Activities of Daily Livings, was bed bound and non-verbal.
A physician's order sheet for that was signed on by the health care provider noted 0.125 mg every four hours for and as needed.
On at 2 PM, the administrator said she was not aware the Physician Order sheet noted the medication was to be given as needed. She said she was trying to contact the health care provider for clarification because the resident was .
Class III

0026 Resident Care - Social & Leisure Activities

Based on the observations and interviews the facility failed to consult with the residents when selecting activities and did not provide an ongoing activities program 12 hours a week, 6 days a week that

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provided diversified individualized and group activities in keeping with each resident's needs, abilities, and interests.

Findings:

During interview with residents it was revealed that there were not activities offered that they wanted to participate in. The residents said the facility staff did not ask them about the type of activities that interest them. The residents felt the activities were for the lower functioning/ residents.

On at 11 AM an observations of the Activities Calendar that was posted revealed it noted the same activities weekly Karaoke, Card games, Bingo, Arts and Crafts, movie day.
The resident who were could participate in bingo or the card games.
Observations at different times through the survey revealed there were some of the residents who were not alert sitting at the table coloring. The other residents were either in their are walking around.
An activity was not scheduled for the day until 5 PM.
Several residents were asked if they had Karaoke, Bingo and card games and they said there was not any Karaoke offered, sometimes card games and the residents who were could not participate in bingo or the card games.
On at 3 PM, the administrator stated Activities were offered and the residents would refuse. She said she had not met with them to discuss their choices for activities.
Class III

0032 Resident Care - Elopement Standards

Based on observations, record review and interview the facility failed to ensure 1 of 1 sampled resident (#1) assessed as an elopement risk had identification on her person at all times.

Findings:

Record review for Resident #1 revealed a Resident Health Assessment Form 1823 that was dated that included a diagnosis of . The Health Care provider noted the resident was an Elopement Risk.
On at 3:10 PM staff B was asked if there were any residents who were at risk for Elopement and she said there was not.
On at 3:15 PM Staff A (the administrator) was asked if there were any residents who were at risk for Elopement and she said there was not.
On at 3:30 PM, the administrator was informed that Resident #1's 1823 noted she was an

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Elopement risk. The administrator said, Resident #1 was no longer an elopement risk and she had not been reassessed. She said she use to have ID for her person and the resident would take it off.
On at 4:10 PM Resident #1 was observed standing in the living there was no type of Identification observed on her.

Class III

0052 Medication - Assistance with Self-Admin

Based on observations and interview the unlicensed staff when providing assistance with the self-administration of medications to the residents, did not follow the appropriate procedure at all times.

Findings:

During resident interview it was revealed that when they received assistance with the self-administration of medication the unlicensed staff did not let them know the name of the medications they were given.
Observations on at 11 AM, Staff B removed the medication package from the locked medication storage and went to the table Where Resident #1 was sitting. She removed the medication from the package and told the resident here is your medication for and placed the pill in the Resident's hand.
Observations on at 12:15 PM, Staff B removed the medication package from the Locked Medication storage that was in the kitchen. She removed the medication from the package and told Resident #7 "here are your chewy's."
Staff B did not follow the proper procedure when providing assistance with the self-administration of medication. She did not in the presence of the resident, read the label, open the container, remove the prescribed amount of medication from the container. On at 12:20 PM Staff B said when she received her medication training she was told that she was required to read the label to the resident. She said she forgot to do it.
Class III

0078 Staffing Standards - Staff

Based on Observations, Record review and interview, the facility allowed Unlicensed Staff to administer medication, this was not consistent with their level of education, training and preparation and experience and did not have a nurse administer medications to 1 of 2 sampled residents (#2) who was not capable of assisting with the self-administration of her medications.

Findings:

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Observations on at 9:45 AM, Resident #2 was observed in bed and was contracted. He was and was not able to talk.
On at 10 AM. Staff B (a non-nurse) said Resident #2 received Hospice Services.
Observations on at 12:30 PM, Staff B was observed Crushing Medication and placing the medication in Applesauce. Staff B took the medication to the fed it (administered) to Resident #2. Staff B said at the time Resident #2 could not take his own medications and staff had to feed it to him. Staff B said she was giving the resident the medication for drooling.
On at 12:35 PM Staff B was asked to provide the medication that she had just given Resident #2. A review of the Medication Package noted 0.125 mg every four hours for and . The MOR noted the same and was marked as given every day-4 times daily.
Record review for Resident #2 revealed a Resident Health Assessment form 1823 dated and noted a diagnosis of Advance , the 1823 noted he was total Care with all Activities of Daily Livings, was bed bound and non-verbal.
Resident #2 was not capable of assisting with the self-administration of medications.
On at 2:30 PM, the Staff A (the Administrator) A Registered Nurse (RN) said she was not aware that unlicensed staff could not give the medications to Resident's who were not capable of Assisting with their medications.
Class III

0091 Training - Documentation & Monitoring

Based on personnel record review and interview the facility failed to ensure staff had certificates that included the required information for 2 of 3 sampled staff (Staff B & C).

Findings:

Personnel Record review for Staff B revealed her last 2 hours Medication training was and did not have the amount of hours and Staff C had a medication certificate for 2 hours that was dated . Both were unlicensed Staff that assisted with the Self Administration of Medication and required to receive the 2 hours of continuing Education on assisting with the self-administration of medication and safe practices in an Assisted Living Facility.
On at 4:15 PM the administrator said Staff B and C both provided assistance with the self-administration of medication and had received the 2 hours continuing education medication training. She provided an agenda for a staff meeting that was dated at 6 PM, attached was a sign in sheet that included Staff B and Staff C's name. The administrator said at the time she provided the staff the 2 hours training.
Review of the Staff meeting agenda revealed it noted the following training's: assistance with medication, resident care, cleaning, phone usage. The Agenda did not document the amount of hours

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for the Medication training, the type of Medication training, nor did it document who provided the training.
Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide for the safe care.

Findings:

Observations during the tour on at 9:30 AM, revealed in # next to the head of the bed of Resident #2 that was by door, there was a hole in the drywall.
On at 4:45 PM, the Administrator said they would repair the hole.

Class III

0162 Records - Resident

Based on record review and interview, the facility failed to record weights semi-annually for 1 of 2 sampled residents (#1) who required assistance with Activities of Daily Living.

Findings:

Record review for Resident #2 revealed a Resident Health Assessment form 1823 dated and noted a diagnosis of Advance , the 1823 noted he was total care with all Activities of Daily Livings, was bed bound and non-verbal. Further record review revealed the last weight available for review was .

On at 2 PM, the Administrator said Resident #2 could not walk or stand and he was not weighed. She said Resident #2 received hospice services and the hospice staff were obtaining his body measurements.

Class III

0167 Resident Contracts

Based on contract review and interview the facility failed have in each resident contract the rights, duties and of residents, other than those specified in the Resident Bill of Rights for 2 of 2 sampled residents contracts (#1 and #2)

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Findings:
Review of contracts for residents #1 and #2 revealed their contracts did not include a statement to inform the residents or their responsible party that all residents must be assessed upon admission and every 3 years thereafter, or after a significant change, whichever comes first.
On at 3 PM, the Administrator stated the above information was not included in the contract.
Class

Z815 Background Screening: Prohibited Offenses

Based on personnel record review and interview, the facility failed to ensure that 1 of 3 sampled staff (B) was in compliance with background screening requirements.

Findings:
Personnel record review for Staff B revealed her last background screening result was dated (more than 5 years)
Review of the Agency's Background Screening website on at 4:10 PM revealed it noted "a new screening is required."
On at 4:30 PM, the administrator said she thought Staff B had already conducted her updated background screening. The administrator said an appointment was being made for tomorrow ( ) to obtain an updated screening.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Administrator
Beggs Pointe Alf
4711 Beggs Road
Orlando, FL 32810

RE: Re-licensure

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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