STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964453	05/05/2016
NAME OF PROVIDER OR SUPPLIER **CONCORDE LOVING CARE INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **13 POPE LANE** **PALM COAST, FL 32164**	

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

0000 Initial Comments

An unannounced complaint survey, CCR #2016002223, was conducted on . Concorde Loving Care had deficiencies found at the time of the visit

0054 Medication - Records

Based on observations, record reviews, and staff interviews, the facility failed to maintain complete and accurate Medication Observation Records (MOR) for Resident # 5 out of 3 Resident records that were reviewed.

The findings include:

Multiple observations were conducted on from 9:15 am - 2:15pm of Resident #5 sleeping in his bed only to get up to eat lunch and then went back to bed.

A review of the Medication Observation Record (MOR) for Resident #5 revealed the resident takes 200 mg 1 tablet 4 times a day.

A review was conducted of the medication storage for Resident #5 and it reveals there is no Garbazepine ( ) on hand. Upon further review of Resident #5 medications there was a bottle of has ( ) 1mg 1 3 times a day and 100 3 times a day labeled for Resident #5 but is not listed on the MOR.

An interview at 1:40pm with Employee A, was asked where the Garbazepine 200 mg tablets are that is ordered by the physician to be given three times a day and was initialed as given this am. The employee pointed to the bottle of and stated this it is, we give him that. (Photographic evidence obtained)

At 1:45 PM Employee A, looked at the MOR and confirmed she wrote the order wrong and the resident should be taking 10mg 3 times a day instead of Garbazepine 200 mg 1 4 times a day as it is written.

An interview with Administrator at 1:50 PM confirmed she gave Resident #5 the 100 mg 1 tablet at 6 am, 12 PM, 2PM and 6 PM and pointed to the 2016 MOR where the Garbazepine is listed and said "Here is the order, I gave him this" and held up the bottle of . The

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administrator confirmed she also gives the resident the medication 4 times a day instead of 3 times a day of how the Garbazepine is written on the MOR. The Administrator was then asked how often she gives the 0.5 mg and she replied three times a day. Both Employee A and the Administrator confirmed the wasn't listed on the MOR and the Administrator stated "I just give it to him because I knew we had an order and we have the bottle." In addition the administrator confirmed since the medication isn't listed on the MOR she just gives and does sign or have any way to verify when and what time she gives it.

CLASS III

0162 Records - Resident

Based on record review and staff interviews, the facility failed to record residents who receive assistance with activities of daily living weights semi-annually for 4 Residents (Resident #4, #5, #6, & #7) out of 5 resident's currently residing in the facility.

The findings include:

A review was conducted of the semi-annual weights for the residents. Resident #4 was recorded on /__ as weighing 164 pounds (lbs.) as well as the same weight for the past 6 months.

An observation was conducted of Resident #4 at 12:05 PM and the resident appeared thin and not to be the weight of 164 lbs.

A weight was obtained at 12:20 PM for Resident #4 which revealed the resident weighed 100 lbs. The Administrator confirmed the weight and stated "This scale is new and I don't think that is accurate, I think a family member gave this to us." The Administrator was asked which scale does she usually weighs the residents with and she was not able to recall.

A weight was obtained for all remaining residents. At 12:50 PM a weight for Resident #6 was obtained of 120 lbs. A record review was conducted for Resident #6 and it revealed the resident weight was listed on /__ as weighing 136 lbs. At 1:05 PM a weight was obtained for Resident # 7 of 120 lbs. A record

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review for Resident #7 revealed resident was listed as weighing 144 lbs. on . At 1:30 PM a weight was obtained for Resident #5 of 158 lbs. the resident was listed as weighing 175 lbs. on .

An interview with the Administrator was conducted at 1:40 PM and confirmed the weight loss for Resident's #4, #5, #6 & #7 and stated "I don't know how accurate the weights we listed are. We just estimate their weights, I don't actually weigh them. I have a hard time getting them on the scale so we don't always weigh them". The Administrator informed me she was not aware that she couldn't guess the residents weights and didn't know that she actually had to weigh the residents and thought she was allowed to guess and estimate the weights. She stated "I just guess what they weighed. I have never been told that I couldn't just estimate". The Administrator confirmed she took CORE training but back in 2009 and she stated "I'm sure they must have changed how we list weight since I've taken it a long time ago."

Based on observation, and staff interviews, the facility failed to have resident records available to the Agency for Health Care Administration at time of survey for 1 resident (Resident #3) out of 3 records that were requested from the facility to review.

The findings include:

An interview with the Administrator on at 9:35 am was asked for the facility records for Resident's #1, #2 and #3. The Administrator questioned why I needed the records for Resident #1 and #3 since both of them were no longer residing at the facility and Resident #3 was .

On at 9:42 AM this surveyor received the facility records for Resident #2 who was discharged from the facility and there were no concerns.

On at 10:10 am the Administrator gave me the Hospice records for Resident #1. The Administrator was asked for the facility records for Resident #1 and she replied "I thought that was her record." The Administrator was again asked for the record on Resident's #1 and #3. She stated "I can't find them. We have been cleaning and I think that they are at a warehouse."

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On [redacted] at 10:15 the Administrator handed me the record for Resident #8. After this surveyor looked at the record and realized it was for the wrong resident I informed the Administrator this was not the record I needed and she was again asked for the record for Resident #1 and Resident #4. The Administrator replied, "Oh I thought that was her record".

An interview with the Administrator on [redacted] at 10:25 AM stated "I don't have the Record for Resident #3 she's [redacted] and we put the record in storage. My daughter is going to go to the warehouse and see if she can find it."

On [redacted] at 10:53 AM the daughter of the administrator Employee A, (Assistant Administrator) entered the facility and wanted to know why we are asking for records of resident's that are no longer living at the facility she stated "This seems unusual."

An interview was conducted with Employee A, on [redacted] at 11:00 am and was asked if she had brought the files for Resident's #1 & #3 with her from storage. She replied "It's like I told my mom we have files all over the place and we are trying to find them."

On [redacted] at 11:30 AM Employee A informed me "I don't think that you should be asking for records for a resident who is [redacted], that is an invasion of her privacy." The employee was again asked for the records for both resident's and was informed this was needed as part of a complaint investigation that I was conducting.

On [redacted] at 12 PM Employee A came and informed me they can't find the records for Resident #1 or Resident #3. She said "I don't where they are, we have looked but we can't find them. I have been filing and they are here somewhere but I can't find them".

On [redacted] at 1:45 PM this surveyor received the facility record for Resident #1.

An observation was conducted on [redacted] at 2:30 PM of a stack of papers on a chair in the garage with name of Resident #3 written on it. Employee A was asked about the papers and she replied "Those aren't her records".

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At time of exit on at 3:15 PM the records for Resident #3 were never obtained for review as requested.

CLASS III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Concorde Loving Care, Inc.
13 Pope Lane
Palm Coast, FL 32164

RE: CCR #2016002223

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016 by a representative 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. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

AF/JM/sm
Enclosure
XG90

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