STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967874	05/11/2016
NAME OF PROVIDER OR SUPPLIER ANGEL CARE AT VERO BEACH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1130 7 AVENUE VERO BEACH, FL 32960	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted at Angel Care at Vero Beach Inc on /16 . The facility had deficiencies identified at the time of the visit.

0054 Medication - Records

Based on observations, interviews and record review, the facility failed to ensure unlicensed staff who assist residents with self-administered medications followed the required standards of practice, for 5 of 5 sampled Residents (1, 2, 3, 4 and 5). As evidence of the facility not updating medication records at the required times, not listing prescribed medications on medication observation records (MOR), and not updating the record to remove old entries of discontinued medications.

The findings included:

1. Review of the facility's medication record book was conducted / at 8:35 AM. All 5 resident records (Resident#'s1, 2, 3, 4 and 5) had no documentation showing the residents received their medications on at 8:00 PM and / 8:00 AM. This was brought to the Administrator's attention who stated the residents received their medications but she had not yet updated the medication observation records (MOR) because she had an appointment the day before. She acknowledged the MOR's are required to be updated each time the medication is offered.

2. Medication review conducted / revealed the following concerns:
a. Review of Resident 2's AHCA Form 1823 dated / documented she requires assistance with self-administration of medications. Further review revealed the health care provider (HCP) ordered D3 1000 units daily, and 3 milligrams (MG), 2 tablets at bedtime. Review of her 2016 medication observation record (MOR) revealed no entries for either of these medications.

b. Review of Resident#1's AHCA Form 1823 dated / documented she requires assistance with self-administration of medications. A written HCP order dated called for Lialda 1.2 MG, 2 tablets daily. Review of her 2016 MOR revealed no entry for this medication.

In an interviews conducted / at 10:13 AM and 11:10 AM, the Administrator stated the pharmacy failed to add the medications but acknowledged staff should be checking the MOR's for completeness and accuracy.

3. Further review of Resident 2's records revealed the monthly MOR's had entries containing medication orders that had been discontinued, dating as far back as 2015. In an interview conducted

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SUMMARY STATEMENT OF DEFICIENCIES
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05/11/16 at 10:09 AM, the Administrator stated the pharmacy failed to remove the medications from the MOR's but acknowledged staff should be checking the MOR's for completeness and accuracy.

Class III

0084 Training - Assis Self-Admin Meds & Med Mgmt

Berry,
Based on record review and interviews, the facility failed to ensure unlicensed staff who assistance residents with self-administration received the required training, for 2 of 4 sampled Employees (A and D).

The findings included:

Employee file review conducted / revealed the following concerns:

1. Employee D, the facility's Administrator and Owner since the facility opened in 2011. Review of her Assistance with Self-Administration of Medication training certificates revealed she received the required training on and / . Further review revealed no documentation showing she received the required 2 hours of training from a licensed registered nurse or a licensed pharmacist in 2015.

2. Employee A, a Caregiver and Medication Technician, was hired when the facility opened in 2011. Review of her Assistance with-Self Administration of Medication training certificates revealed she received the required training on / and . Further review revealed no documentation showing she had received the required 2 hours of training from a licensed registered nurse or a licensed pharmacist in 2015.

In an interview conducted / at 2:20 PM, the Administrator stated she knew she had copies of the 2015 training certificates somewhere. At survey's end at 4:30 PM, the Administrator was not able to produce the 2015 training certificates for Employees A and D.

Class III

0085 Training - Nutrition & Food Service

Based on record review and interviews, the facility failed to ensure the facility's food service designee

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	AL11967874	**05/11/2016**
NAME OF PROVIDER OR SUPPLIER **ANGEL CARE AT VERO BEACH INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1130 7 AVENUE** **VERO BEACH, FL 32960**	

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

received required training on an annual basis, for 1 of 1 sampled Staff (Employee A).

The findings included:

Review of Employee A, the Administrator's personnel file revealed the most recent training she received was 1 hour on 04/18/16. The training certificate was issued by an online training program, and was titled Food Handling in an Assisted Living Facility (ALF), it did not include nutrition in an ALF in the title. Also, there was no indication the training was provided by a certified food manager, licensed dietician, registered dietary technician or health department sanitarian.

This was discussed with and acknowledged by the Administrator on at 2:25 PM.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Angel Care at Vero Beach Inc
1130 7 Avenue
Vero Beach, FL 32960

Dear Administrator:

This letter reports the findings of a state licensure 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 representative. Should you have any questions please call this office at 561 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/
Enclosure

XG90

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