STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910473	07/19/2016
NAME OF PROVIDER OR SUPPLIER **FOREST GLEN LODGES, INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **7435 PLATHE ROAD** **NEW PORT RICHEY, FL 34653**	

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

0000 Initial Comments

Assisted Living Facility

On , 20016, through , 2016, a biennial re-licensure survey in conjunction with a revisit to CCR#2016004420 of (aspen event id# RA5Q12) and a revisit to CCR#2016003149 of (aspen event id# EH5S12) was conducted at Forest Glen Lodges, Assisted Living Facility. Deficient practice was identified relative to the biennial survey.

(lic# 5243)

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to have completed health assessments, (Form 1823) for 4 (Resident #12, Resident #13, Resident #14 and Resident #15) of 4 residents sampled for health assessments.

Findings included:

A record review on of Resident #12's health assessment revealed he was admitted to the facility on / / . He had a health assessment dated / / and there was no weight or height documented on the form. Also there was no documentation on what kind of assistance the resident needed for his medications and there was no attached medication list to the health assessment form.

A record review on / of Resident #13's health assessment revealed he was admitted to the facility on . He did not have a health assessment for the facility. The resident did have a health assessment with another facility's name and address on it in his medical record. The facility had 30 days to acquire a health assessment for Resident # 13 after he was admitted.

A record review on of Resident #14's health assessment revealed she was admitted to the facility on . She had only one health assessment dated . The health assessment was not given to the facility within 30 days following her admission to the facility. Resident #14 needed a new health assessment completed every three years or when a significant change in condition takes place. The resident was admitted to hospice on and discharged from hospice on / / . The

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resident was once again admitted to hospsice on and discharged again on . There were no new health assessments completed after these two significant changes in condition.

A record review on of Resident # 15's health assessment revealed he did not have a dated health assessment. The resident had the first page of the health assessment but the other four pages were missing. These missing pages included: An evaluation of whether the individual will require supervision or assistance with the activities of daily living; Any special diet required by the individual; A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; Whether the individual has signs or symptoms of , or any other communicable , which are likely to be transmitted to other residents or staff; A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider and A medical examination to be completed either 60 days before admission to the facility or 30 days after the resident's admission to the facility.
When interviewed on at 2:00 pm, the administrator verified the health assessments for the four residents were not complete.

Class III

0052 Medication - Assistance with Self-Admin

Based on record review, observation and interview, the facility failed to provide assistance with self administration of medication to 2 (Resident #14 & Resident #15) of 4 residents sampled for medication pass observation.

Findings included:

A record review on of Resident #14's health assessment dated showed the resident was to be assisted with medications. The resident had two medications scheduled at noon, , 325 mg and , 0.5 mg. There was an order to crush the medications unless contraindicated

Med Tech, Staff # E was observed at 11:05 am in the memory care unit reading the MOR and opening the locked medication cart to get out the medication for Resident #14. She compared the MOR to the label, sanitized her hands and then she crushed the two medications and put them into a small cup with pudding. She was observed locking the medication cart and walking over to Resident#14 who was half

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sitting and half lying in a recliner chair. The resident was observed to have her legs pulled up to her waist and was continually moving her arms around. Staff #E called the resident by name and told her she was there to give the resident her medications, and . She took the spoon and put it into the resident's mouth. She did this until the medication in cup was gone. The resident did not assist with the administration of medications.

Staff #E stated on at 11:10 am the resident can no longer assist with her medications. I give them to her because she can no longer hold the spoon because her arms move all the time.

Med Tech, staff #F, in the memory care unit was observed on / at 11:15 am crushing the medication and putting it into a small cup with pudding. She put all of the medication on a spoon and went over to Resident #14. The resident was shaking so much that she could not hold the spoon with the medication on it so staff #F put the spoon in the resident's hand and put her hand over the resident's hand and pulled the resident's hand up to her mouth and put the spoon in the resident's mouth using her hand over the resident's hand. The med tech took the spoon from the resident and put her arm down by her side. The resident could not assist staff #F with taking her medication because of her shaking.

Staff #F stated on / at 11:20 am that the resident can help sometimes but mostly she does not assist with medications. Staff #F stated she would give the medications to Resident #14 if the resident could not assist with the medications.

A record review on / of Resident #15's health assessment did not show what kind of assistance for medications the resident needed. The facility said they were assisting with Resident #15's medications.

Med Tech, staff # E on / at 11:15 am was observed in the memory care unit reviewing the MOR against the label on Resident's #15 medications. She sanitized her hands and they she took the patch from the locked medication cart. She took the patch to the resident who was sitting at the dining in his wheelchair. She called him by name and told him she was there to give him his medication, patch. She initialed the patch and dated it. She handed him the patch to the resident who looked very puzzled and mumbled something and threw the patch on the table. Staff #E picked up the patch and handed it back to the resident. Once a again he threw it on the table. This time staff #E asked the resident to move forward in his wheelchair so she could take off the old patch on his right shoulder and took the new patch out of the wrapper and put the new patch on his left shoulder. The resident allowed her to put on the patch but he did not assist her in any way with the patch.

Staff #E stated on that Resident #15 can not assist with putting on his patch. I have to do it for him.

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Med Tech, staff #F in the memory care unit stated on at 11:25 am, Resident #15 can not assist with putting on his patch. I put it on for him.

The facility is no longer assisting Resident #14 and Resident #15 with their medications. The facility is administering the medications with unlicensed staff.

Class III

0079 Staffing Standards - Levels

Based on record review, observation and interview, the facility failed to provide enough staff to meet the needs of the residents regarding assisting with meals for 7 (Resident #14, Resident # 17, Resident #18, Resident #19, Resident #20, Resident #21, Resident #22) of 8 residents in the memory care unit who were sampled for assistance with diets.

Findings included:

Record review on / / of the facility's staffing hours showed there were over the minimum required staffing hours of 375 for the week of 10 through , 2016 for 54 residents. This schedule was broken down to 2 direct care staff in memory care on the first shift and 2 direct care staff in memory care on the second shit and one direct care staff in memory care for the third shift. The med tech does all the medications in both the memory care and assisted living side. There were 24 residents in the memory care unit on / .

Observation of the noon meal on revealed there were two direct care staff in the memory care unit. Staff # G was getting the residents into the dining staff #H was plating up the food and serving it to the residents who were sitting at tables of four residents each. When staff #G had all of the residents in the dining started finishing up the plating of the food and started putting the food on the tables. Resident #14 was observed sitting in a wheelchair at the back table and staff # H came over and removed her from the table and placed her against the back wall near the back table because she was moving her arms all around and staff #H did not want the resident to knock over the glasses on the table. The resident stayed there until it was time to fed her eight minutes later.
Staff #H was trying to fed seven residents at two tables. She was very busy hopping from one table to another trying to get the residents fed. After staff #G had finished with getting the food out, she joined the second table and started feeding the three residents at the seond table. The other residents who

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were no being fed were sitting and fidgetting at the table waiting their turn. Finally more staff was called in to help with the feeding.

Staff #H when interviewed on at 11:45 am stated there should be more help for the residents who need assistance with meals. It is hard for one person to feed two tables of residents who need help with eating.

Even thought the facility had enough required staffing hours they were not meeting the needs of the residents regarding assisting the residents with dining in the memory care unit.

Class III

0091 Training - Documentation & Monitoring

Based on record review and interview, the facility failed to have training certificates which documented the required direct care staff training for 2 (Staff #B and Staff #C) of 3 direct care staff sampled for training certificates.

Findings included:

A record review on of Staff #B's employee file revealed she was hired on / 16 and she had completed the required direct care staff in-service training provided by the facility on . She signed a sign in sheet with each required training. There were no certificates or copies of certificates documented in staff #B's personnel file which contained the following: the title of the training program; the subject matter of the training program; the training program agenda; the number of hours of the training program; the trainee ' s name, dates of participation, and location of the training program; the training provider ' s name, dated signature and credentials, and professional license number, if applicable. Upon successful completion of the required direct care staff training, the training provider must issue a certificate to the trainee.

A record review on of Staff #C's employee file revealed she was hired on and she had completed the required direct care staff in-service training provided by the facility on . She signed a sign in sheet with each required training. There were no certificates or copies of certificates documented in staff #C's personnel file which contained the following: the title of the training program; the subject matter of the training program; the training program agenda; the number of hours of the training program; the trainee ' s name, dates of participation, and location of the training program; the

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training provider ' s name, dated signature and credentials, and professional license number, if applicable. Upon successful completion of the required direct care staff training, the training provider must issue a certificate to the trainee.

When interviewed on at 2:00 pm, the assistant administrator confirmed there were no certificates completed for the required direct care staff trainings.

Class III

0162 Records - Resident

Based on record review and interview, the facility failed to record the admission weight of 1 (Resident #12) of 4 residents sampled for weights and failed to record the weight every six months for 1 (Resident # 14) of 4 residents sampled for weights.

Findings included:

A record review of the weight log on showed Resident # 12 did not have a weight sheet in the weight log. There was no admission weight on the health assessment and the facility did not weigh Resident #12 when he was admitted.

A record review of the weight log on showed Resident #14 did have an admission weight but the facility stopped weighing the resident on / . Resident #14's health assessment dated stated she needed assistance with all activities of daily living and therefore needed to have her weight recorded semi-annually.

When interview on at 2:05 pm, the administrator verified there was no admission weight for Resident #12 and there were no weights recorded for Resident #14 since 2015.

Class III

0167 Resident Contracts

Based on record review and interview, the facility failed to have the facility's representative sign and date

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the contract for 2 (Resident # 12 & Resident #13) of 2 residents' contracts sampled for contract review. The facility failed to have 2 (Resident #12 & Resident #13) of 2 residents sampled for contract review date and sign the facility contract.

Findings included:

A record review on of Resident #12's facility contract showed the resident did not date the contract in multiple areas when he signed the contract and the facility's representative did not sign and date the facility contract when it was executed.

A record review on of Resident #13's facility contract showed the resident did not put the date and sign the contract in one area of the contract and the facility's representative did not sign and date the facility contract when it was executed.

When interviewed on at 2:10 pm, the administrator verified the facility contracts were not complete for the two residents.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Forest Glen Lodges, Inc.
7435 Plathe Road
New Port Richey, FL 34653

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on 18-19, 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.

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Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia I
for Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90