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	AL11966315	09/28/2016
NAME OF PROVIDER OR SUPPLIER **SMYRNA WEST ASSISTED LIVING FA**	STREET ADDRESS, CITY, STATE, ZIP CODE **301 MILFORD PLACE** **NEW SMYRNA BEACH, FL 32168**	

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0000 Initial Comments

On , 2016, a biennial re-licensure survey with Limited Nursing Services was conducted at Smyrna West Assisted Living, (License #10584). Deficient practice was identified during the survey.

0052 Medication - Assistance with Self-Admin

Based on observations and staff interviews, the facility failed to have unlicensed staff properly assist with self-administration of medications for 3 Residents (Resident #2, Resident #8 and Resident # 9) evidenced by not informing the residents what medication they are taking, out of 4 residents observed for medications assistance.

The findings include:

1) An observation was conducted on at 1:15 PM of Employee A, Medication Technician, assisting Resident #2 with 10 Milligrams (mg) 1 tablet and #3 1 tablet. The employee handed the resident her pills and asked her to take her medications but did not instruct her on the pills she was taking.

2) An observation was conducted on at 1:18 PM of Employee A, Medication Technician, assisting Resident #9 with her and . The employee handed the resident her medications and asked her to take the medications but did not instruct her on the pills she was taking.

3) An observation was conducted on at 1:27 PM of Employee A, Medication Technician, assisting Resident #8 with a Primodone tablet. The employee handed the resident her pill and asked her to take the medication, but not instruct her on what she was taking.

An interview was conducted on at 1:30 PM with Employee A, who confirmed she should have informed the resident's of the medications they were taking.

An interview with the Administrator on at 4:40 PM confirmed Employee A, should have informed Resident's #3, #8, & #9 of the medications she was assisting them with,

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CLASS III

0055 Medication - Storage and Disposal

Based on observations, record reviews, and staff interviews, the facility failed to properly store medications in a secured locked cabinet for Resident #2 out of 14 residents who receive assistance with medications.

The findings include:

An observation was conducted upon entering the facility on at 10:00 AM the door to the nurses station being opened.

An observation was conducted on at 10:20 AM of the medication the facility and a card of for Resident #2 was observed on the counter and not locked in a cabinet as well as another card of medication for an unsampled resident, nasal sprays and an identified patch which had staff initials on it.

Multiple observations were conducted during the survey of the door to the medication and no staff members inside the the medications left unattended.

An interview with the Administrator on at 4:40 PM confirmed the medications are going back to the pharmacy and the door to the medication be closed and locked at all times if a staff member is not in the .

CLASS III

0056 Medication - Labeling and Orders

Based on observation, record review, and staff interviews, the facility failed to use an "Alert" label on a

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medication container which had a direction change for 2 Resident's (Resident # 2 and Resident #8) out of 3 resident's observed for medication assistance.

The findings include:

1) An observation was conducted on at 1:15 PM of Employee A, Medication Technician, assisting Resident #2 with 10 Milligrams (mg) 1 tablet.

A review of the medication label for Resident #2 reads: 10 mg 1 tablet by mouth every 6 hours as needed for muscle spasms.

A review of the Medication Observation Record (MOR) for Resident #2 revealed 10 mg 1 tablet 4 times a day. (photographic evidence obtained)

An interview with the Employee A, on at 1:30 PM confirmed the label and MOR did not match and the medication needed an "Alert" sticker on it.

2) An observation was conducted on at 1:28 PM of Employee A, Medication Technician, assisting Resident #8 with Hycosamine 10mg 1 tablet.

A review of the medication label for Resident #8 reads: Hycosamine 0.125mg 1 tablet by 4 times a day.

A review of the Medication Observation Record (MOR) for Resident #8 revealed an order for Hycosamine 0.125mg 1 tablet 3 times a day. (photographic evidence obtained)

An interview with the Employee A, on at 1:30 PM confirmed the label and MOR did not match for Resident #8 Hycosamine and needed an "Alert" sticker on it.

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An interview with the Administrator on at 4:40 PM confirmed the Medications for Resident #2 and #8 were different from the MOR and needed an " Alert" label on them.

CLASS III

0076 (DNROs)

Based on interview and record review, the facility failed to properly document on 4 of 14 residents who had executed ('s), including residents #2, #3, #6, #9, and #10.

The findings include:

A record review for Resident # 6 showed he had a in his chart, but it was printed on white paper. Resident #9 and #10 also had 's printed on white paper.

An interview with the Administrator at 3:58 PM on , she was asked about the 's. She stated, all but one resident has a (14 total).

The Administrator was asked to show how staff knows that a resident has a , and she pulled out the Medication Observation Record (MOR). Some residents had the order copied in the MOR, and some did not. She acknowledged the inconsistency.

The Administrator was asked where in the chart the order would be located. Resident #3's was in front of his chart, printed on white paper. She acknowledged that she knew it was supposed to be yellow paper.

In a later interview with the Administrator at 4:25 PM on , Resident #2's chart was reviewed for her . She stated she knows she had the order because she she was sent out to the hospital with it recently, and it is possible she was sent out with the original. At this time there was no in her file, and no indication that the resident had revoked her wishes to change her code status. The Administrator stated, she would call the resident's daughter to obtain a new form.

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Photo evidence obtained.

Class III

0078 Staffing Standards - Staff

Based on record review and interview, the facility failed to ensure 2 of 3 employees had the required communicable assessment completed prior to providing direct care to residents, and that employees were aware of what were.

The findings include:

1. Employee B began employment on /. During a record review, there was no communicable statement in the employee's file indicating she was cleared for work within the required time frame.

Employee C was most recently employed on /. She worked for the facility in the past and had a communicable statement completed on , during her previous employment. There was nothing in her current employee file that indicated she was free from ( ) since that statement was completed.

At 1:55 PM the Administrator confirmed that she could not locate the missing information for Employee B or C.

2. Employee A indicated that she did not know what a was when she was interviewed on at 3:20 PM.

Employee B was interviewed at 2:40 PM on . She was asked if she knew what the term " " stood for, and she did not know.

Employee C was interviewed at 3:10 PM and she was asked what " " stood for. She could not

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name what the letters represented but she reported that if someone has a _____, "we have to do everything to keep them alive".

The Administrator was asked at 3:58 PM on about the staff's knowledge about 's. She implied that all of her staff really do know what they are, but she would need to set up more training.

Class III

0081 Training - Staff In-Service

Based on interview and record review, the facility failed to provide 2 of 3 employees with trainings within the required timeframe.

The findings include:

During a record review for Employee D and E, it was discovered that they did not have copies of the mandatory trainings for Adverse Incident reporting or and Neglect.

Employee D was listed as having a start date of / and the 30 day window to complete the trainings had passed.

Employee E was listed as having a start date of and the 30 day window to complete the trainings had also passed.

The Administrator was asked about the completion of the trainings and she agreed to follow up, and in an interview at 1:55 PM on she reported she could not locate any information about them taking the required trainings.

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0090 Training -

Based on interview and record review, the facility failed to provide training on for 2 of 3 employees reviewed.

The findings include:

During a record review for residents D and E, it was discovered that they did not have copies of the mandatory trainings on

Employee D was listed as having a start date of / and the time frame to complete the trainings had passed.

Employee E was listed as having a start date of and the time frame to complete the trainings had also passed.

The Administrator was asked about the completion of the trainings and she agreed to follow up, and in an interview at 1:55 PM on she reported she could not locate any information about them taking the required trainings.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observations, and interviews, the facility failed to provide a safe living environment, evidenced by the facility bolting all the facility doors, which has the high likelihood or potential for harm due to the residents not being able to exit the facility independently in the event of an emergency affecting 4 residents out of the current census of 15 who can ambulate independently.

The findings include:

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On at 2:15 PM an audible alarm could be heard in the hallway. The alarm continued to ring for 12 minutes. An observation was made of the box from where the alarm was heard which read: "Front Door."

On at 2:40 PM the front door was observed and revealed a sign posted on the front door that read: "Attention all visitors please see any staff member and they will let you out." The front door was attempted to be opened unsuccessfully even after holding down the cash bar on the door. A bolt was observed at the very top of the door which appeared to be locked. When the lock was turned, the door opened freely. (photographic evidence obtained)

On at 2:43 PM an interview was conducted with Resident #2 who confirmed she is not able to leave the facility without a staff member unlocking the door. She was asked if she could freely come and go and she replied, "No, they have to let me out, due to the door always being locked."

An observation on at 2:44 PM was made of all the doors in the facility, which open to the outside. All the doors were observed with either a bolt or keyed locked (with no key in the door) preventing the doors from freely being opened. All doors (3 exit doors and the main front door) were observed in the locked position and couldn't be opened.

An interview with Employee B, on at 2:45 PM was asked if the front door is always locked. She replied "Yes mam, we keep it locked all the time. Nobody can come and go unless we unlock it."

An interview was conducted with the Administrator and owner of the facility on at 2:50 PM who confirmed they lock all of the doors at the facility and the residents cannot access the doors at the facility independently and require the staff to open the doors and can ' t get out on their own. The owner said, "We have resident's that would leave here if we didn't lock them in. They are smart and watch us go in/out and would open the door and leave the facility."

A call was placed on at 2:55 PM to the local Fire Marshall who confirmed he has spoken with the owner several times about removing the bolts to the doors at the facility. He stated the Administrator confirmed he put the locks on the doors so residents couldn't get out.

An interview with Resident #1 on at 3:25 PM was asked how do you go outside. She replied, "I can't. I don't know how to get out of the locked front door. I spoke with the owner and he said that he would show me how to do it but never has."

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An interview was conducted on at 3:3 PM with Employee F, and was asked when does the facility lock the front doors and she replied, "They ' re always locked."

An interview with the owner on at 4:25 PM confirmed the Fire Marshall has instructed him to remove the bolts from the facility doors to the inability of residents to get out in the event of an emergency, with the door locked.

CLASS II

0161 Records - Staff

Based on interview and record review, the facility failed to provide documentation that elopement drills were conducted on a biannual basis.

The findings include:

On at 1:55 PM, the Administrator was asked to produce documentation that elopement drills were completed biannually.

The Administrator returned at 4:25 PM to indicate that she could not find the forms. She stated she kept them in a binder, but she does not know where the binder is.

The Administrator produced a document showing 2 employees were trained on , and 2 employees were trained on for elopement drills, but these did not encompass all the employees and did not show that biannual elopement drills were conducted.

Class III

Z814 Background Screening Clearinghouse

Based on interview and record review, the facility failed to update the employee roster with the agency's

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clearinghouse for 3 employees.

The findings include:

During a review of the facility's employee roster, published on the agency's background screening portal, it was discovered that Employee D, E, and I were not on the current roster of employees.

Employee D's start date was listed as / in her file and she was not on the roster. She was on the schedule for and was actively employed with the facility at the time of the survey.

Employee E's start date was listed as in her file, but she was listed as a former employee. She was on the schedule for and was actively employed with the facility at the time of the survey.

Employee I was an employee of the facility and on the schedule for , but she was not listed on the employee roster.

An interview with the administrator at 4:44 PM she confirmed she is in charge of the roster, and had not updated the employees' and their status changes listed above yet.

Unclassified

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

Beth Snyder
Smyrna West Assisted Living Facility
301 Milford Place
New Smyrna Beach, FL 32168

Dear Mrs. Snyder:

This letter reports the findings of a biennial re-licensure survey conducted on 2016 by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the State (5000) Form, which indicates there were deficiencies noted during the inspection.

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

1) A0152- Physical Plant- Safe Living Environment- Class II

The Assisted Living Facility failed to provide a living environment that was free from hazards by preventing resident access to exit door. This had to potential to effect 4 residents who were capable of self-preservation, in the event of an emergency.

Your plan of correction must include the following, which you are directed to implement as indicated below by the time frames specified:

1) The facility must in-service all staff regarding emergency preparedness and evacuation procedures. The in-service must have an agenda. The facility must maintain documentation of the completion of this training which must be kept on file at the facility, and be available for review by the Agency. This shall be completed by

2) The facility must remove any locking mechanism on exit doors, in which the sole responsibility in unlocking that exit door is placed with a single individual, or cannot be reached by residents capable of using exit doors. This shall be completed by

3) The facility must develop a written, detailed plan of how the facility will ensure the safety and well-being of the residents regarding access to exit doors in all situations. The plan must include how the facility will ensure appropriate supervision to meet the needs of all current

and future residents at the facility. The facility must maintain documentation of the plan which must be kept on file at the facility, and be available for review by the Agency. This shall be completed by .

All required documentation set forth above, should be directed to the attention of Mrs. Jana Meyering, Health Facility Evaluator Supervisor and sent to:

Agency for Health Care Administration
Health Quality Assurance, Jacksonville Field Office
Attention: Jana Meyering
921 N. Davis Street, Bldg. A, Suite 115
Jacksonville, FL 32209
Phone: (904) 798-4201
Fax: (904) 359 - 6054

Nothing in this Directed Plan of Correction limits the Agencies authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Mrs. Amanda Beagles, Survey and Certification Support Branch, at 850-412-4662 or Jana Meyering, Jacksonville Field Office, at 904-798-4201.

Sincerely,

Jana Meyering

Jana L. Meyering, Q.I.D.P.
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JD/JM/RED/sm

D7JR