STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953542	11/01/2016
NAME OF PROVIDER OR SUPPLIER **CORNERSTONE LONGWOOD LEASING, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **480 EAST CHURCH AVENUE LONGWOOD, FL 32750**	

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

0000 Initial Comments

A complaint investigation #201612523 was conducted at Cornerstone Longwood Leasing, LLC Assisted Living Facility License #5315 on . / / . Cornerstone Longwood Leasing, LLC Assisted Living Facility had deficiencies at the time of the investigation.

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to honor request for privacy for 1 of 3 sampled residents (#2) when requested.

Findings:

Interview on / / at 8 AM with resident #2 who stated he has a concern with not having any privacy in his . He explained there was no privacy when his was being provided care with his activities of daily living (dressing & bathing etc.). He further explained that his who is and requires assistance to be changed every 2 hours by the caregivers. According to the resident he informed the facilities ' management about his concern & requested to have a privacy curtain. He was not sure who he told.

Observation of resident #2's / / at 8 AM revealed the set up in an L shape, very visual (obvious) for both residents ( ) to see each other dressing.

Interview on / / at 5:30 PM with resident #2 who again stated his concerns with privacy and remembered who he informed about the request of the privacy curtain. He stated he told the "blond lady, staff Tracy" did not know last name. Resident #2 confirmed again that he can see when his is being changed and assisted with incontinence care. He further stated his can see him dressing. He added that he dresses by his closet slightly behind the closet wall.

Interview on / / at 5:45 PM with the administrator and maintenance supervisor who confirmed that they both were not aware this was an issue.

Class III

0053 Medication - Administration

Based on review of Medication Observation Record (MOR), observations and interviews, the facility did

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	AL11953542	11/01/2016
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SUMMARY STATEMENT OF DEFICIENCIES
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not have a nurse available to administer medications and as ordered by the physician and to obtain Sugars for 3 of 3 sampled residents (#1, #2 and #3). The nurses provided medications after the order was changed and discontinued for 1 of 3 sampled staff (#3) and refused to give 1 of 3 sampled resident (#2) his medications when he requested it.

Findings:

1. On / / at 8:10 AM observations of the first floor dining breakfast was being served revealed resident #2 was overheard saying "I have not had my yet. The nurse is not here."

On / / at 8:20 Resident #2 said he did not get his this morning because there was no nurse at the facility. He said he was to have his sugar checked first, take his and eat. He said he did not get it yesterday in the morning and afternoon because there were no nurses to give it to him and when they arrived he refused it because it was too late.

Observations at 8:25 AM-resident #2 was observed finishing his breakfast.

On / / at 8:26 AM the caregiver who provided assistance with medication on the first floor of the facility said the nurses administered the to resident #2. He provided a sugar record and said the nurse used that to chart when they gave the . He said the nurse had not arrived yet to give the .

Review of the sugar record revealed it was a log that had a Row for the date, for Fasting Sugar (FBS) results before breakfast, Sugar (BS) before Lunch, Supper and bedtime. There was a row that noted and another row for comments. The row for comments had signatures, the sugar results and amounts were noted daily except on / before breakfast and lunch and on / / before breakfast.

On / / At 8:30 AM-the administrator said there were 5 nurses employed by the facility and two quit yesterday / . She added that the Director of nursing fired one of them and she did not know why. She said one of the nurses started her shift on / in the morning and then turned in her keys, she did not give the medications to the resident who needed them. She said the director of nursing cleaned out her office and turned in her keys she did not know why. She tried all day on / to get nurses. Finally, she was able to get a nurse from an agency. She said there should be a nurse at the facility now.

On / / at 8:40 AM a caregiver said she was responsible for giving the medication on the second floor memory care unit only to the residents who could assist and did not need their medications

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	AL11953542	11/01/2016
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SUMMARY STATEMENT OF DEFICIENCIES
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crushed. She said the nurses were to give the other medications and she said there was no nurse available yet. She was giving out her medications. She was asked at the time if any resident received on the second floor she said yes there was one. She identified resident #3 she pointed and said he is the one sitting outside the medication .

On / / at 8:45 a nurse arrived and identified herself as a Registered Nurse (RN). She said she was working for an agency and was now hired by the facility as of last night (/). She said she came in around 6:30 PM on / and left around 10 PM. She gave medications to the ones who needed them and . She said she was supposed to be in at 8 AM, but got held up in traffic, because she did not realize how long it took to get to the facility. She said she had not given any medications.

On / / At 1 PM the Sugar Record was reviewed for Resident #2 again, the space for / / that was previously blank, now had a result written for sugar result before breakfast, the results were 306. And noted 10 .

Examples of the previous BS results before breakfast for the resident were as follows: -137, -125, -158, -146, -144, -143, -156, -148.
There was never a result as high as the one obtained on / / .
The Record was not accurately charted because the there was no Fasting Sugar obtained before breakfast on / / .
On / / at 2:30 PM the RN said she gave the resident his after he had eaten and obtained his sugar after his breakfast. She said there was no other document to log the results on that was used by the facility.
Record review for Resident#2 revealed a hospital discharge order dated / , it noted lispro 10 unit before meals for 30 days and Lantus 100 units 36 units once a day at bed time. Further record review revealed there was a MOR for the found in the record.
On / / at 2:30 PM the RN said she gave the resident his after he had eaten and obtained his sugar after his breakfast. She said there was no other document to log the results on that was used by the facility.
Further record review revealed a note written by a License Practical Nurse who name was not legible that noted the following:
" at 4 PM the resident refused the and , due at PM. Resident educated on consequences of skipping medication doses. director of Nursing (DON) executive director and physician and brother notified."
-6:30 PM" received call from resident brother. Brother demanding that his brother be taken to the store 7-eleven on the hour and requested that medication for 4 PM dose is given. Brother advised that the time limit expire for 4 PM dose but that patient would receive 8 PM medication and 7:30 PM ."

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SUMMARY STATEMENT OF DEFICIENCIES
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Review of the Medication Order revealed it noted 50 mg 1 two times a day. The MOR noted 50 mg take one tablet by mouth twice a day and noted the medication to be given at 8 AM and 4 PM. Further record review revealed there was no order found that noted the resident had to take the medication exactly at 8 AM and 4 PM daily.
On / / at 5:10 PM Resident #2 said he did refuse his medications because he was mad and wanted to leave the facility and was not allowed to go. He said after speaking with his brother he wanted to take it. He said he asked for the medication and the nurse told him it was too late to take the , and because it was to be taken at 4 PM. The resident said the was to be taken twice daily and that should be given every twelve hours which should be 8 AM and 8 PM. He said he would like to receive it at 8 PM not 4 PM.
On / / at 5:30 PM, the administrator said the resident refused the medication at 4 PM because he was upset. She said she thought the medication could only be given 1 hour before and 1 hour after the time on the MOR. And was not aware that if it was twice daily and if the physician had not written an order for it to be given at a specific time he could have received the medication later.

2. Review of the record for resident #1 revealed he has a Guardianship Order and was admitted to Hospice care on and the Health Assessment (1823) dated documented type of assistance for medications was "needs assistance with self-administration of medications". In addition, the Hospice physician noted that it is okay to crush medications , & because patient spits out pills, but do not crush .

Review of the facility's schedule revealed there was no nurse working on / to crush the , which was to be taken at 8 AM (after medication designated time ordered) and was not given timely.

On / / at 8:40 AM, an interview was attempted with the resident but she was and unable to answer any questions, and a few minutes later observed caregiver feeding her breakfast in the dining .

On / / at 2 PM, review of the Guardianship Order dated declares that the resident is , and cannot live independently. Furthermore, resident 1's Medication Observation Record (MORs) review revealed that on / that the eye drop medication Latanoprast 0.005% OPTH Solution eye drops, directions to instill 1 drop in both eyes as directed every night at bedtime was not initialed by staff or evidence that this medication was given to the resident.

on / / at 2:30 PM, the Registered Nurse that was assisting the facility that worked for an agency said on / she remembers giving Resident #1 her crush medications. She said she did not give any resident an eye drop. She said, she was provided a list of the residents who needed their

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953542	11/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE LONGWOOD LEASING, LLC	480 EAST CHURCH AVENUE LONGWOOD, FL 32750

SUMMARY STATEMENT OF DEFICIENCIES
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medications crushed and that was all she did.

3. Resident 3's Medication Observation Record (MORs) review revealed for 2016 an order for 100 U/ML vial ; directions to inject per sliding scale before breakfast & dinner twice daily.

Also the MORs revealed an order for Lantus Solo Star Pen 15 ml ; directions to inject 38 units Sub Q as directed twice daily.

MORs revealed for an Aviva Plus test strips used to test glucose as directed 3 to 4 times a day.

It is required that a nurse is on staff to administer and .

Furthermore, resident 3's AHCA Form 1823 Health Assessment dated revealed that type of assistance for medication was " needs medication administration".

On a verbal physician order changing Lantus Solo star pen 15 ml to inject 30 units Sub Q at bedtime only. MORs revealed that on dates and (2 days) was not initialed being given indicating missed medication.

On / / a verbal physician order changed to check sugar Q AM before and breakfast.

On / / at 4 PM, the administrator provided a physician order dated or (written date not clear) that Lantus 30 unit ' s Q hs ; and Q AM; and D/C 100 U/ML vial.

Reviewed 2016 MORs revealed that resident was still being administered on dates of (8 days) verified by initials on the MORs given.

Review of Resident #3's MOR revealed it noted inject per sliding scale before breakfast and dinner twice daily, was left blank on / / .

Class III

0054 Medication - Records

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953542	11/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE LONGWOOD LEASING, LLC	**480 EAST CHURCH AVENUE LONGWOOD, FL 32750**

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

Based on Medication Observation Record (MOR) review and interview, the facility failed to maintain accurate MOR's for 1 of 3 sampled residents (#2).

Findings:

On /// at 8:26 AM the caregiver who provided assistance with medication on the first floor of the facility said the nurses administered the to resident #2. He provided a sugar record and said the nurse used that to chart when they gave the .
Review of the sugar record revealed it was a log that had a Row for the date, for Fasting Sugar (FBS) results before breakfast, Sugar (BS) before Lunch, Supper and bedtime. There was a row that noted and another row for comments. The row for comments had signatures, the sugar results and amounts were noted daily except on / before breakfast and lunch and on /// before breakfast.
Review of Resident #2's MOR for and / revealed the was not listed.
Further review of the Sugar Record revealed it did not include any known the resident may have; the name of the resident's health care provider, the health care provider's telephone number; the name, strength, and directions for use of each medication was left blank. There was no way to determine who the staff was that gave the resident his because the staff did not initial.

On /// At 1 PM the Sugar Record was reviewed for Resident #2 again, the space for /// had a result written for sugar before breakfast the results were 306. And noted 10 . BS before lunch was 186 and noted 10 . Examples of the previous BS results before breakfast for the resident were as follows: -137, -125, -158, -146, -144, -143, -156, / -148. There was never a result as high as the one obtained on ///.
The Record was not accurately charted because the there was no Fasting Sugar obtain before breakfast on ///.
On /// at 2:30 PM the RN said she gave the resident his after he had eaten and obtained his sugar after his breakfast. She said there was no other document to log the results on that was used by the facility.

Record review for Resident#2 revealed a hospital discharge order dated /, it noted lispro 10 unit before meals for 30 days and Lantus 100 units 36 units once a day at bed time. Further record review revealed there was MOR for the found in the record.
On /// at 2 PM, the administrator said she had searched for a MOR for the Administration and could not locate it.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953542	11/01/2016
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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

0079 Staffing Standards - Levels

Based on observation of the facility's staff schedule posted and interview, the facility failed to ensure that 2 of 7 sampled staff (A&B) written work schedule pattern was accurate and current.

Findings:

Observation on / / at 7:30 AM, reviewed the facility's staff schedule for week / - / revealed staff B was listed to work 7 AM- 3 PM on / / in the memory care unit and staff B was absent during this scheduled time.

An interview on / / at 3 PM with the administrator, who confirmed that 4 staff were on the schedule to work today but only 3 staff were present.
Review of the staff schedule revealed Staff A was listed on the schedule for as working from 7 AM until 3 PM. Review of her time sheet revealed Staff A signed in on at 7 and signed out at 9:36 (AM or PM was not listed).

On / / at 2 PM, the administrator said Staff A did sign in at 7 AM and signed out at 9:36 AM on because she had and emergency. She confirmed the schedule was not correct.

Class III

0093 Food Service - Dietary Standards

Based on observation and interview, the facility failed to follow posted week in use menu approved for week in use by registered dietician; and failed to serve correct portion size approved by registered dietician; and failed to maintain a substitute log in the facility for the past 6 months & document substituted items served with also providing resident change in a planned menu one week in advance.

Findings:

Observation on / / at 7:45 AM, kitchen staff wrote on the dining after erasing the night before dinner served. Breakfast written on board was: scrambled eggs, pancakes, "cockfruit", and cottage cheese. Breakfast served was: scrambled eggs, pancake, fruit cocktail, cottage cheese, coffee, milk, water, and orange juice. Breakfast approved correct menu by registered dietician for / / (week - / /) was: assorted fruit juice, assorted cereal, cheese omelet,

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	AL11953542	11/01/2016
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

sausage, pancakes with syrup, yogurt, and milk, coffee or beverage of choice. Further observation revealed the wrong menu was posted on bulletin board near front lobby, the menu was dated for last week .

During a brief interview on / / at 8:20 AM with several residents while in the dining their concerns that the kitchen was out of butter today, they were not being served any meat with breakfast this morning, and there was no syrup on yesterday's breakfast (/).

Interview on / / at 8:30 AM with food server and cook who both confirmed that there was no butter and no sausage or any meat substitute to serve. They also confirmed that the facility was out of yogurt, therefore cottage cheese was served similar to yogurt and did not comment on the issue of not serving syrup on / .

Interview on / / at 8:50 AM with the cook who confirmed that he did not have written documentation of the last 6 months of substitutions.

Interview on / / at 3 PM with the administrator who confirmed she was not aware that the facility was out of the breakfast items.

Review of the lunch menu for the day revealed it noted:
Toss Salad
Chicken
Mariana sauce
Rice pilaf
Ice cream sundae
Milk coffie/ tea decaf

/ / at 12:25 PM revealed the residents were served chicken , rice pilaf and squash casserole. The food on their plates were small portions. Residents were asked if the portions served was enough and some responded not really but that was the amount they were usually served. The residents said they could get more if there was more left. The residents said they were not served a salad or the Mariana Sauce.

On / / at 12:35 PM-observations of the dietary staff revealed he used a utensil that was similar to an ice cream scooper to serve the food. The dietary aide was observed serving one scoop of the rice and one scoop of squash casserole onto the plates. He said at the time he only gave one scoop. He used the scoop to measure the food. He was asked at the time what were portion sizes to be given for each of the foods served. The dietary aide said he did not know. Further observations revealed there

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SUMMARY STATEMENT OF DEFICIENCIES
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was a spoon used to serve the chicken and there was no way to determine on the spoon the appropriate amount to be served. He said they were not served a salad. He said they were not given Mariana sauce because it really did not go with the chicken.

On |/|/ at 12:40 PM an interview with the cook who said they used the scoops to serve the food, he was asked at the time how did they determine the resident received the accurate amounts of ounces according to the menu prepared by the dietitian. He said they used the scoops. The cook was asked to provide documentation of the required dietitian approved portion sizes that were to be used. The cook left the area and obtained out of an envelope the portion size menu for the day. The portion sizes were not available to dietary staff to follow. Review of the portion sizes for the day revealed the following:

Toss Salad ½ cup (not served)
Chicken -3 ounces
Mariana sauce "2 oz. (ounce) lad "
Rice pilaf 4 ounce
Ice cream sundae 1 slice
Milk coffle/ tea decaf

The cook provided a scooper that was being used, the scooper was only 2 ounces. The cook said at the time they have other utensils that were used. The cook provided another scooper and said this is a green handle one and is 4 ounces. Review of the scooper revealed there was nothing on the scooper that noted the amount of ounces. The cook was also asked if the residents were served Salad. The cook said they were not served salads because a previous cook told him if a vegetable was on the menu not to serve both. He was informed at the time the facility had to serve food that was on menu that was approved by the dietitian to ensure the resident obtain their appropriate nutrients.

Further observations revealed the residents were not served Ice Cream Sundae's they were served Ice Cream Sandwiches.

On |/ / at 1:30 PM the administrator said the dietary staff should be using the appropriate measuring utensils, she further said the facility did not have the items for the Sundae because the truck just arrived on |/|/ .

Class III

0152 Physical Plant - Safe Living Environ/Other

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Based on observations and interview, the facility did not ensure the material on the sofa in the second floor memory care unit was not torn.

Findings:

Observation on / / at 8:30 AM revealed the material on sofa in the Memory Care unit common area was torn and had holes in some places.

The administrator was present at the time and confirmed the findings.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Cornerstone Longwood Leasing, LLC
480 East Church Avenue
Longwood, FL 32750

RE: CCR #2016012523

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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