STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11966315 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SMYRNA WEST ASSISTED LIVING FA	301 MILFORD PLACE NEW SMYRNA BEACH, FL 32168

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0055	Correction	ID Prefix A0056	Correction	ID Prefix A0076	Correction
Reg. # 58A-5.0185(6) FAC	Completed	Reg. # 58A-5.0185(7) FAC	Completed	Reg. # 58A-5.0186 FAC	Completed
LSC		LSC		LSC	
ID Prefix A0078	Correction	ID Prefix A0081	Correction	ID Prefix A0090	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(11) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0152	Correction	ID Prefix AZ814	Correction	ID Prefix	Correction
Reg. # 58A-5.023(3) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			[signature]	12/8/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/28/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966315	R 12/01/2016

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

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

0000 Initial Comments

A follow-up visit to a biennial survey was conducted at Smyrna West Assisted Living (Lic #10584) on 12/01/2016. Smyrna West had deficiencies at the time of the visit.

0052 Medication - Assistance with Self-Admin

Based on interview, observation, and record review, the facility failed to prepare medications within view of the residents receiving them, for 3 of 3 residents observed (Residents #2, #3, and #9).

The findings include:

At 1:10 PM on / , Employee A was preparing medications for Resident #9. Employee A was located in the medication , where the medications and records were kept, but the door was shut and there was no visibility for the residents in the dining of the .

Employee A read the record, put the medications into the dosage cup, and opened the door and brought the medications to Resident #9.

At 1:16 PM, Employee A was again in the medication the door closed, and Resident #2 was in the dining no way to watch Employee A prepare the medications. Employee A put the medications into the dosage cup in the medication . She proceeded to open the door and give the cup to the resident to take.

Employee A then returned to the medication at 1:17 PM, with the door shut, prepared Resident #3's medications. She placed the medication into the cup and brought it out to the Resident, but he was not present when she portioned the medications.

A review of the facility's policies showed that staff guidance for Medication Self Administration included "reading the label, opening the container, and removing the prescribed amount of medication with the resident".

The errors in medication assistance were discussed with the Administrator at 2:30 PM on / and she was informed that the staff was not following the facility's policy.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966315	R 12/01/2016
NAME OF PROVIDER OR SUPPLIER **SMYRNA WEST ASSISTED LIVING FA**	STREET ADDRESS, CITY, STATE, ZIP CODE **301 MILFORD PLACE** **NEW SMYRNA BEACH, FL 32168**	

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

0091 Training - Documentation & Monitoring

Based on record review and interview, the facility failed to ensure employee trainings were summarized on a training certificate that encompassed all required components, as evidenced by 5 of 5 files reviewed for Employees B, D, E, G, and J.

The findings include:

Employee B showed a start date of . The training certificate in her chart consisted of a paragraph that listed the trainings, but the certificate lacked the following information: the program agenda, the hours of each training subject, the location of the training program, the trainer's name, and the trainer's credentials.

Additionally, the form used to indicate she had training was not signed by the trainer, and the only signature on the form was from Employee B.

Employee D had a hire date of / . His training documentation lacked the program agenda, the hours of each training subject, the location of the training program, the trainer's name, and the trainer's credentials, and his forms also lacked signatures from the trainer.

Employee E showed a start date of , and the same form was used to show her trainings. It lacked the same information and it was also only signed by the employee and not the trainer.

Employee G had a start date listed as . His forms are similar to the other employees in the it also did not include the program agenda, the hours of each training subject, the location of the training program, the trainer's name, and the trainer's credentials.

Employee J was hired / and had the same information missing from his training record.

The Administrator was interviewed about the missing information at 2:30 PM on and she acknowledged the missing information.

Photo evidence obtained.

Class III

0161 Records - Staff

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966315	R 12/01/2016

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

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

Based on interview and record review, the facility failed to ensure their entire direct care staff participated in biannual elopement drills.

The findings include:

At 1:25 PM on , elopement drill documentation was requested of the Administrator.

The information she provided showed that some employees engaged in an elopement drill, but Employee K and Employee L were not listed on any sign in sheets.

Employee K's start date was listed on the Employee Roster as , and Employee L's was listed as .

Employees K and L were both listed on the current facility schedule.

In a follow up interview with the facility Administrator at 1:45 PM, she confirmed they work the 11 to 7 shifts and she did not have any evidence at the time of the investigation to support that they had engaged in a biannual elopement drill.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2017.

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 (904) 798-4201.

Sincerely,

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

AW/JM/sm
Enclosure

BBT7

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