STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968460	11/17/2016
NAME OF PROVIDER OR SUPPLIER **ROSA'S CARING MADISON**	STREET ADDRESS, CITY, STATE, ZIP CODE **587 SW BUNKER STREET** **MADISON, FL 32340**	

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

0000 Initial Comments

Bienniel with LNS/LMH
An unannounced Biennial Survey (with specialty license Limited Nursing Services and Limited Mental Health) was conducted at Rosa's Caring Madison (license number 12371) on / . At the time of survey there were deficiencies identified.

0030 Resident Care - Rights & Facility Procedures

Based on observation, record review and staff interview the facility failed to ensure the rights of 5 of 5 residents (1-5) by not providing a clean, living environment; failed to provide a comfortable, clean mattress for 1 of 5 residents (#5); failed to provide a 45 day notice of discharge in the resident's contract for two of two contracts reviewed (residents #3 & 4), and failed to ensure the rights of 1of 5 residents in regard to ensuring dignity not providing a belt when wearing pants for 1 of 5 residents (#3).

Findings include:

On / a tour was conducted of the facility to find the followings:
An observation was conducted of the front entrance, the shower curtain had a large amount of brownish, black stains (photographic evidence obtained). Also observed in the several bottles of cleaning chemicals sitting under the sink and in the corner (photographic evidence obtained).
An observation was conducted of the second only commode and sink which revealed in the upper corner of the black stains (photographic evidence obtained). An observation was conducted of Resident #5 , during this tour and observation resident #5 reported that his mattress was not comfortable, the springs in the mattress were broke; he got up and uncovered the mattress which had a large tear in the mattress (photographic evidence obtained).

On / at approximately 3:00pm, an interview was conducted with the Administrator who confirmed the findings.

On / a record review was conducted of the Resident contracts for two residents (#3 & 4). Upon reviewing contract it was documented that noted that a 30 day notice of discharge was given instead of the required 45 day notice.

On / at approximately 3:00pm an interview was conducted with the Administrator who was not aware that the requirement was 45 day notice of discharge.

On / upon entrance into the facility at 9:30AM, resident #3 was observed holding his pants to

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keep from falling down, no belt or suspenders observed. Observation at 10:00AM, resident observed sitting on sofa, got up to go outside and holding up pants with hand, no belt or suspenders. Observation at 12:00pm observation made of resident #3 who was observed holding his pants up with hand, underwear showing. Observation of resident #3 at 1:15pm coming in side kitchen door holding up pants with hand, underwear showing. On / at approximately 1:15pm interview with resident revealed he did not have a belt.
On the afternoon of / an interview was conducted with employee B who reported that resident #3 did not have a belt. Employee B reported that she sent belt home with sister on , , 2016 and belt did not return. Employee B reported that resident needed to go and change pants. Employee B did not tend to resident's need, nor did she encourage resident to go change his clothes.

class III

0056 Medication - Labeling and Orders

Based on interview and facility and resident record review, the facility failed to ensure that medications maintained in central storage, were documented on the Medication Administration Record (MAR), and that physician orders were documented for 1 of 2 Resident records reviewed for medications. (Resident #3)

The findings include:

Based on surveyor observation at the time of survey, the facility maintains resident medications for each resident in a separate plastic bin stored in a locked closet.

A review of Resident #3's Medication Observation Record, bin with medications and Physician Orders was conducted. Resident #3's Medication Administration Record (MAR) was compared to the medications and labels in the resident's medication bin, and physician orders. The medication bin contained a medication card for 10mg (milligrams) #18 tablets, dated / , with instructions to "take one tablet by mouth every day as needed." The medication card failed to indicate what the medication was to be used for. A review of the resident's Medication Administration Record and physician ordered failed to identify the medication or its continued use.

The Medication Administration Record identified, two separate entries for glucose readings - both entries were for three times a day [Accu-check Aviva Plus, use as directed three times day and True Plus Ulta Thin, use as directed three times a day with machine], The order date on the MAR was . The MAR idenified the glucose testing was performed three times a day every other day, and failed to document glucose readings. A separate log book, identified glucose

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results documented performed once a day, not three times a day or every other day as documented on the MAR. The resident's record failed to identify an order for glucose testing.

On / at approximately 11:30am, an interview was conducted with the Care Giver, Staff Member A. Staff Member A was asked about the medication, Loratidine, for Resident #3. She stated the resident has not taken that medication in a long time. She was asked what the medication was used for - she stated, she thought it was for " :" [is an , for relief of symptoms.] The medication card did not indicate what the medication was for. Staff Member A stated she performs the resident's glucose testing, but couldnt' explain why it was being performed every other day and not three times a day as per the MAR.

On / at approximately 1:00pm during an interview with the Facility Adminsitrator, she was asked about Resident #3's glucose testing, and that the physician order for testing was unable to be located in the Resident's medical record. She stated that the physician had indicated that the resident doesn't really need glucose testing any longer, but was unable to locate documentation that indicated this or the previous order for testing 3 times daily.

Class III

0078 Staffing Standards - Staff

Based on interview and facility personnel record reviews, the facility failed to ensure that staff received annual testing for for 1 of 2 staff members reviewed (Staff A)

The findings include:

On / , facility personnel record review was conducted for Staff Member A. Staff Member A failed to have annual testing for . The record included a document to indicate, highlighted in green, chest-x-ray results were normal for . Handwritten beside this line was " ". Last documented skin test for ( ), was dated , which indicated it ws negative. There was no result for 2016.

A chest x-ray ( ) only documents active for anyone with a prior positive skin test. A (chest x-ray) would not show latent , and therefore is not an appropriate test for .

On / at approximately 1:00pm, interview with the Administrator indicated she thought a was sufficient. There was no signature on the document presented and was not able to verify if the

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highlighting and words " " were documented after the facility received the document indicating a normal chest x-ray.

Class III

0081 Training - Staff In-Service

Based on interview and personnel record review, the facility failed to ensure that staff who provide direct care to residents, received a minimum of 1 hour inservice training, regarding resident elopement, within 30 days of employment for 1 of 2 staff records reviewed (Staff A).

the findings include:

On 11/ , personnel record review was conducted for the Care Giver, Staff Member A. Staff Member A began employment with the facility on / . The Staff member's record failed to include training regarding resident elopement.

On / , at approximately 10:15am an interview was conducted with Staff Member A. She stated, no residents have eloped from the facility and if someone did, she would look for them, then call the Facility Administrator and call the police if she needed to. She says the residents are really good about telling her where they are going.

On / at approximately 1:00pm during an interview with the Administrator, a request was made for elopement training for Staff A. She stated she thought she had completed it. She was not able to locate training for Staff A.

Class III

0093 Food Service - Dietary Standards

Based on observation, interview and record review the facility failed to serve therapeutic diet as ordered by the health care provider for 1 of 5 residents (#3) and the facility failed to maintain a 3-day supply of nonperishable food and water.

The Findings:

On / at approximately 12:00pm, an observation was conducted of the lunch meal. Resident #3 was observed to be eating regular meal with thin liquids.

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A record review was conducted of Resident #3 Discharge diet from the hospital dated 6/14/16 which indicated: Resume usual eating habits, mechanical soft with honey thick liquids. A record review was conducted of Resident #3 health assessment special diet instructions: diet with honey thick liquids: precautions.

On / at approximately 3:00pm, an interview was conducted with the Administrator who reported that she was not aware of the discharge diet and the health assessment special diet instructions. The Administrator reported that she would make contact with resident #3's health care provider.

On / an observation was conducted of the facility's 3-day supply of nonperishable food and water. The three day emergency supply was observed and upon observation of the water supply, the package of bottled water was found expired with the date of , 2016 and package covered with dust. The rice had expiration date of , 2014, canned products of diced tomatoes with expiration date of .

On / at approximately 1:00pm an interview was conducted with Employee B who reported that she cooks out of the emergency food bin, which contained the expired food supply. The noodles were in open package inside plastic bag with holes in it.

On / at approximately 3:00pm, an interview was conducted with the Administrator who confirmed the findings of the 3-day emergency bin. She stated that she purchased the water and did not understand why the water had expiration date on it.

class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview the facility failed to provide a clean, comfortable mattress for 1 of 5 residents (#5) and failed to provide a clean living environment.

The Findings:

On / a tour was conducted of the facility to find the followings:
1. An observation was conducted of the front entrance, the shower curtain had a large amount of brownish, black stains (see photographic evidence). Also observed in the several bottles of cleaning chemicals sitting under the sink and in the corner (see photographic evidence).

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2. An observation was conducted of the second bathroom with only commode and sink which revealed in the upper corner of the bathroom several black stains (see photographic evidence).
3. An observation was conducted of Resident #5's room. The resident's mattress had a large tear in it (see photographic evidence)..

On / at approximately 3:00pm, an interview was conducted with the Administrator who confirmed the findings.

class III

L243 LMH - Training

Based on record review and interview the failed to ensure 1 of 3 employee records (employee C) reviewed received a minimum of 3 hours of continuing education for limited mental health training.

The Findings:

A record review was conducted of Administrator and two care givers personnel records. The following was found:
Employee C received 8 hours of limited mental health training on / . The care giver had not received 3 hours of continuing education.

On / at approximately 3:00pm, an interview was conducted with the Administrator who reported that she was not aware that staff had to receive 3 hours of continuing education.

class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Rosa's Caring Madison
587 SW Bunker Street
Madison, FL 32340

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representatives 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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

DH/dh
Enclosure
XG90

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