STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	12/05/2016
NAME OF PROVIDER OR SUPPLIER **AMORE' AT KANNER HIGHWAY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1634 S. KANNER HWY. STUART, FL 34994**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on review of facility staff schedule, Background Screening Clearinghouse review, and a staff interview, the facility failed to maintain a current employee roster for all employees of the facility.

The findings included:

On , a review was conducted of the facility's employee roster located on the Agency's Background Screening Clearinghouse website. At this time, two (2) current employees (Staff A and B) were not listed on the roster. Additionally, a previous employee, Staff C, was still listed on the roster as an employee.

Review of the facility's staffing schedule revealed Staff A and B are current employees at the facility.

During interview with the Administrator on / at 12:00 PM, she confirmed she had not completed the Clearinghouse Employee Roster with the addition of Staff A and B, and Staff C removed as of the date of this survey.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS

Based on employee record review and a staff interview, the facility failed to obtain a new background screening for 1 out of 5 employees reviewed, who had a break in employment greater than 90 days from the date that the Level II Criminal Background Screening was completed and the employee's date of hire (Staff G).

The findings included:

On , during record review for Staff G, it was noted Staff G's date of hire was and the date of his background screening was / .

A review of Staff G's employment history showed Staff E had a break in employment greater than 90 days between the date his background screening was completed and the employee's date of hire at this facility.

An interview was conducted with the Administrator on at 1:30 PM. At this time, neither the Administrator or Staff G could provide any documentation or information showing Staff G did not have a

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	**12/05/2016**
NAME OF PROVIDER OR SUPPLIER **AMORE' AT KANNER HIGHWAY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1634 S. KANNER HWY.** **STUART, FL 34994**	

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

break in service of more than 90 days from a previous position that required a criminal background screening by a specified agency. No additional documentation was presented at this time.

Unclassified

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	12/05/2016
NAME OF PROVIDER OR SUPPLIER **AMORE' AT KANNER HIGHWAY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1634 S. KANNER HWY.** **STUART, FL 34994**	

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

0000 - Initial Comments

An unannounced Relicensure survey was conducted on 5th, 2016 at Amore' At Kanner Highway LLC (License #9636). The facility had deficiencies identified at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, it was determined the facility failed to have a face-to-face medical examination and completion of a new health assessment (ACHA Form 1823) by a health care provider after a significant change, and to have an Interdisciplinary (Integrated) Care Plan, which specifies the services being provided by Hospice and those being provided by the facility, developed and signed by both the Hospice provider and the Administrator, for 1 of 2 residents whose records were reviewed (Resident #1).

The findings include:

1) On , during record review for Resident #1, a completed Health Assessment (AHCA Form 1823), dated / / , was reviewed. The current Health Assessment did not contain any information related to the Resident #1's enrollment in Hospice, or to the presence of an unstageable on this resident's left heel, as documented in Hospice Doctor's evaluation notes and care notes documented by Hospice Aide. The latest Health Assessment also did not reflect the current level of Activities of Daily Living for Resident #1.

A review of the Hospice Physician's initial notes, dated / / , documented the resident is "bedbound". Hospice CNA Plan of Care Notes, dated / , documented that Resident #1 transfer was done with Hoyer with 2 person assist.

During an interview with the Hospice Nurse on at 10: 05 AM; she stated, "There was a Sacral , but this has been resolved, currently there is a left Heel which is unstageable ...there is a section that is and some tissue is off around the area ....It has been ongoing for about a month. This is due to poor circulation related to ; not pressure related. The right great toe is beginning to develop some issues also due to circulation."
2) During record review for Resident #1, no Interdisciplinary/Integrated Care Plan for services to be coordinated between Hospice and the facility could be located with the resident's chart or the Hospice Notebook.
A request for the Integrated Care Plan was made to the Administrator. The Administrator contacted the Hospice nurse, who provided the care plan with date of . This Care Plan did not contain signature of the facility Administrator.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	**12/05/2016**
NAME OF PROVIDER OR SUPPLIER **AMORE' AT KANNER HIGHWAY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1634 S. KANNER HWY.** **STUART, FL 34994**	

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

During interview conducted with Administrator on 12/05/16 at approximately 1:30 PM, she stated that the facility and Hospice have good communication between the two. She further stated that the staff at the facility and her were aware of what services Hospice was responsible for and what services the facility care staff were responsible for. However, their was no written Integrated Care Plan received identifying these separate responsibilities.
The Administrator stated in regards to resident being "bed-bound", Hospice wanted the resident to remain in bed with boots on heels and turned every 2 hours due to on heel. Administrator stated that the staff gets Resident #1 up and into her recliner from time to time if resident wants to get up or as tolerated.
The Administrator confirmed Resident #1's latest Health Assessment did not accurately reflect the resident's current health status, and a new Form 1823 should have been completed due to significant change.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on observation, interview, and record review it was determined the facility failed to ensure the Medication Observation Record (MOR) was accurate for 2 out of 4 sampled residents who required assistance with the self-administration of medication.

The findings included:

During observation of Staff F, who provided assistance with self-administration to residents during the morning medication pass on / , the following residents received their scheduled 8:00 AM medication as follows:

1) Resident #'s 8:00 AM medications were provided on / beginning at 9:50 AM:

a.
b.

2) Resident #'s 8:00 AM medications were provided on beginning at 10:00 AM:

a. HCTZ
b.
c. Hydroxysine

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	12/05/2016
NAME OF PROVIDER OR SUPPLIER AMORE' AT KANNER HIGHWAY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994	

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

d.

Review of the 2016 MORs for these residents revealed some of their medications were scheduled for 8:00 AM as noted above, and other medications scheduled for 9:00 AM.

During interview with the Administrator on at 12:30 PM, she confirmed that the facility's policy is that medications shall be provided within a one (1) hour window prior to the scheduled time or one (1) hour after the scheduled time, but that this specification was not in the facility's written policy and procedure. She acknowledged that the aforementioned residents' medication times should be changed to 9:00 AM on the 2016 MORs to ensure the medication is distributed within one (1) hour of the designated times on the MORs. No additional documentation was presented at this time.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on staff record review and staff interview, the facility failed to ensure 1 of 5 employees (Staff G) submitted a written statement from a health care provider documenting that the employee does not have any signs or symptoms of communicable , and a negative ( ) examination by health care provider .

The findings included:

During record review for the Staff G (Food Designee), date of hire / , a signed health statement by health care provider, verifying this employee was free from all communicable , including , could not be found. A request was made to the administrator for the documentation, but the administrator was unable to produce such documentation at the time of survey.

On / at 2:00 PM, the Administrator acknowledged the absence of the written health statement and negative examination for Staff G.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on record review and an interview, the facility failed to ensure a staff member who has completed courses in both First Aid and ., and holds a currently valid card documenting completion of such courses, was in the facility at all times.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	12/05/2016
NAME OF PROVIDER OR SUPPLIER AMORE' AT KANNER HIGHWAY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1634 S. KANNER HWY. STUART, FL 34994	

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

The findings included:

Review of the personnel file for Staff B who works during the 7:00 PM to 7:00 AM shift revealed no current training with a valid card in First Aid. Review of the written work schedule showed Staff E also works alone with Staff B during the 7:00 PM to 7:00 AM shift. Review of the personnel file revealed Staff E did not have current training with a valid card in First Aid on file.

The Administrator was interviewed at approximately 12:30 PM on / / and confirmed that the documented training in First Aid was not present and available for review for these staff members who were left in sole charge of residents during the night shift. The facility provided no additional documentation of the required training for review at this time.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and an interview, the facility failed to ensure that 2 out of 2 sampled staff (Staff A and B) who provide direct care to residents had received the required in-service training within 30 days of employment .

The findings included:

a) Review of the personnel file for Staff A, who provides direct care to residents, revealed there was no documentation of in-service training in the facility's Elopement policies and procedures dated within 30 days of employment. Staff A was hired on / / .

b) Review of the personnel file for Staff B, who provides direct care to residents, revealed there was no documentation of in-service training in the facility's Emergency Procedures and Incident Reporting (1 hour) and Residents' Rights and Neglect and (1 hour) dated within 30 days of employment. Staff B was hired on / / .

The Administrator was interviewed at approximately 12:30 PM on and confirmed that the documentation was not present and available for review. The facility provided no additional documentation of the required training for these staff members at this time.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	12/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMORE' AT KANNER HIGHWAY LLC	1634 S. KANNER HWY. STUART, FL 34994

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

0082 - Training - / - 58A-5.0191(3) FAC

Based on record review and an interview, the facility failed to ensure that 1 out of 2 sampled staff (Staff A) had completed training in / within 30 days of employment.

The findings included:

The personnel file for Staff A was reviewed on / for documentation of training in / dated within 30 days of employment. There was no documentation of this training available for review. Staff A was hired on . The Administrator was interviewed at 12:30 PM on and acknowledged that the documentation was not present and available for review. The facility provided no additional documentation at this time.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on record review and an interview, the facility failed to ensure that 1 out of 2 sampled staff (Staff A), who provides direct care to residents, had received at least one hour of training in the facility's policies regarding 's ( ) within 30 days of hire.

The findings included:

Review of the personnel file for Staff B, who provides direct care to residents, revealed there was no documentation of at least one hour of training in the facility's policies regarding 's ( ) within 30 days of hire. Staff B was hired on / / .

The Administrator was interviewed at 12:30 PM on and confirmed that the documentation was not present and available for review. The facility provided no additional documentation of the required training at this time.

Class III

0092 - Food Service - General Responsibilities - 58A-5.020(1) FAC

Based on record review and an interview, the facility failed to ensure that 1 out of 2 sampled staff (Staff B) who prepares or serves food, and who has not taken the ALF core training, had received a minimum of 1-hour in-service training within 30 days of employment in safe food handling practices. It was also determined the Food Designee had failed to complete the 2 hour Food and Nutrition Training before

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	**12/05/2016**
NAME OF PROVIDER OR SUPPLIER **AMORE' AT KANNER HIGHWAY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1634 S. KANNER HWY. STUART, FL 34994**	

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

assuming responsibility for the facility's food service.

The findings include:

a) The personnel file for Staff B was reviewed for documentation of a minimum of 1-hour in-service training completed within 30 days of employment in safe food handling practices. There was no documentation of this training available for review. Staff B was hired on / . The Administrator was interviewed at approximately 12:30 PM on and confirmed that the documentation was not present and available for review. No additional documentation was presented at this time.

b) On , during Food Service Designee's employee record, it was discovered that the Food Designee was hired on / , but had not completed the 2 hour Food and Nutrition Training before assuming Food Designee responsibilities. The Food Service Designee had completed a Food Safety Management Course, but the training was not provided by a state approved trainer, nor was the training was not specific for Assisted Living Facilities.

During an interview with Food Service Designee on at 1:00 PM, it was confirmed that the Food Safety Management Course was not specific for Assisted Living Facilities, and no other Food and Nutrition training was completed. The Food Designee also confirmed he had not completed CORE Training.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and staff interview, the facility failed to maintain a safe living environment, as it relates to being clean and sanitary, and to maintain furnishings in good working order, for 5 of 10 inspected (# 4, 11, 15, 16, 17).

The findings include:

On , an observational tour was conducted of a sample of 10 random Resident . Of the inspected, the following concerns were found (photo evidence available):

1. # -
   a) The carpeting in the dirt and debris and was heavily stained.
   b) The pull cord on call system located next to toilet in resident caked in brown matter.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	**12/05/2016**
NAME OF PROVIDER OR SUPPLIER **AMORE' AT KANNER HIGHWAY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1634 S. KANNER HWY. STUART, FL 34994**	

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

2. Room #11 -
   a) The carpeting in the room contained dirt and debris and was heavily stained.
   b) There were numerous spots and smears of brown matter, resembling fecal matter, on frame and on entry doors.
   c) Toilet bowl rim and over-the toilet seat contained dirt, debris, and stains
   d) around toilet was dirty.

3. # -
   a) The white wicker dresser's top drawer was broken.
   b) The white wicker night stand had missing pull knob on top drawer, and the bottom drawer was broken.
   c) had spots and smears of brown matter resembling fecal matter.
   d) Brown staining around door handle on outside of

4. # -
   a) The carpeting in the dirt and debris and was heavily stained.
   b) Dresser in the resident's dust and debris on surfaces.
   c) The side of the resident's toilet seat had brown matter resembling fecal matter; the base of toilet contained dirt and residue.
   d) was visibly dirty.
   e) was visibly smeared with unknown substance.

5. # -
   a) The carpeting in the dirt and debris and was heavily stained. Some of these stains were brown in color and heavily concentrated at the entrance to the
   b) There were spots and smears of brown matter, resembling fecal matter, on beside toilet, on door frame and on entry doors.
   c) Wall damage (torn on near toilet).
   d) was visibly dirty.

These issues were discussed with the Administrator on at 1:52 PM. She stated the facility does not employ separate housekeeping services; The care staff are responsible for housekeeping duties, also.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965260	12/05/2016
NAME OF PROVIDER OR SUPPLIER **AMORE' AT KANNER HIGHWAY LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1634 S. KANNER HWY. STUART, FL 34994**	

SUMMARY STATEMENT OF DEFICIENCIES
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0162 - Records - Resident - 58A-5.024(3) FAC

Based on resident record review and staff interview, the facility failed to maintain on the premises all physician orders and Hospice Nurse's notes for 1 of 1 Hospice resident (Resident #1).

The findings include:

During record review for Resident #1 on , the physician orders for 1/2 bed rails and Hospice Nurse's Notes could not be located within the resident's medical record. When requested, staff could not provide this documentation.

On at approximately 10:30 AM, the administrator acknowledged the physician order and Hospice Nurse's Notes were not on the premises, and she contacted the Hospice nurse to request the missing documentation.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

Administrator
Amore' At Kanner Highway LLC
1634 S. Kanner Hwy.
Stuart, FL 34994

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 , 2017.** 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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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