STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965743	12/16/2016
NAME OF PROVIDER OR SUPPLIER **CENTURY OAKS**	STREET ADDRESS, CITY, STATE, ZIP CODE **4001 STACK BOULEVARD** **MELBOURNE, FL 32901**	

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

0000 - Initial Comments

Complaint Investigation #2016009906 was conducted on , , , and in conjunction with Complaint Investigation #2016010149. Century Oaks had deficiencies at the time of the visit.

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

Based on record reviews and interviews, the facility failed to properly assess 1 of 2 sampled residents with a pressure for continued residency (#7).

Findings:

On at 1:36 PM, the power of attorney (POA) for Resident #7 stated she has concerns about the night shift and the care of Resident #7. The POA stated Resident #7 lives in the memory care unit. The POA stated Resident #7 stated she is not allowed to use the rest night.

On at 12:10 PM, staff M expressed concern about the pressure on Resident #7. Staff M stated the pressure is in the crease of Resident #7 and Resident #7 is not turned enough during the night shift.

On at 5:10 PM, the administrator stated Resident #7 has a pressure which is being treated by a home health nurse. The administrator provided the home health nurses' notes.

On , Resident #7's file documented only 5 entries in the nurses' notes. The file did not have any additional information on the pressure beyond what was listed in the nurses' notes. They included:
- Resident #7 is getting daily treatment. Resident #7 likes to lay in bed to rest.
/ - COC completed for resident obtaining .
/ - ARNP stated pressure in starting to improve. Resident #7 slide and out of bed.
/ - ARNP reviewed pressure .

On , review of the documentation provided by the facility as home health notes were determined to be certification of services documentation.

On / at 1:12 PM, the home health agency representative stated the home health agency would provide the nurses' notes for review. The representative stated she was familiar with Resident #7 and stated it had been documented Resident #7's was covered with fecal matter and from not

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being cleaned. The representative stated the facility was not compliant in supporting Resident #7. The representative stated if the facility had provided better care the pressure would have healed sooner.

On at 5:50 AM, staff OO stated resident care staff are responsible for turning Resident #7 every two hours. Staff OO showed the form used which was hanging on the . The form was blank.

On at 6:10 AM, staff QQ stated staff B reviews the care of Resident #7 in her meetings and stressed to keep her dry but most of the resident care staff are not at the meeting and don't know to keep her dry.

On at 9:26 AM, staff M stated she is licensed to perform care and could keep the dressing clean and treated but stated she has been instructed not to perform those services.

On at 9:54 AM, the administrator stated the facility had provided all of the nurses' notes which were provided by the home health agency. The administrator said their duty is to provide a two hour check and to turn Resident #7. The administrator stated the information is documented on a form hanging on the . The administrator stated the completed forms are in Resident #7's file. When she was told the file had been reviewed and documentation on turning Resident #7 was not in the file, the administrator stated, "That is where it is kept." The administrator stated she is not aware of the status of the and not aware if the facility is getting information from the home health nurses.

On at 2:35 PM, home health registered nurse (RN) A stated the facility did not follow the instructions left by her and the other RNs on the care of Resident #7. The RN stated most times when she went to care for Resident #7, she found the dressing wet and covered in fecal matter. The RN stated the facility never reached out to her and asked the condition of the resident.

On at 9:41 AM, home health RN B stated she worked with Resident #7. RN B stated she always had a difficult time finding staff in the facility. RN #7 stated she would provide the staff direction on the care of Resident #7 but they did not follow up with Resident #7's needs. RN B stated she spoke to staff B but nothing was ever done about her concerns regarding Resident #7.

On at 10:02 AM, the administrator stated the facility provided the Agency for Health Care Administration with all of the nurses' notes. The administrator stated the facility does not do care for residents. The administrator was unaware if the home health agency knew the facility did not provide care. The administrator stated the facility had access to the nurses' notes on line but when

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shown the actual notes, she acted as if it was the first time she had seen them. The administrator stated the home health nurses were available to provide care 24/7 for Resident #7 when they called.

On at 12:15 PM in an interview with the home health agency representative, the representative stated the facility had the ability to contact the home health agency 24/7 if they needed support on the care of Resident #7. The representative stated the records document the facility never called for support.

On / , a record review was conducted of the home health agency nurses' notes regarding Resident #7. They include the following:
- the resident is discharged from physical from the home health agency. At the time of discharge, the resident has no or not stageable
- the resident is being admitted to the home health agency for a . The ability to walk is severely limited, cannot bear own weight and must be assisted into chair or wheelchair. The resident makes occasional slight changes in body or extremity but unable to make frequent or significant changes independently. The resident frequently slides down in bed or chair and requires repositioning with . The resident is day and night. The resident requires prompting under stressful or unfamiliar conditions. The resident depends entirely upon another person to dress lower body. The resident unable to get to and from the toilet but is able to use a bedside commode. The resident depends entirely upon another person to maintain toileting hygiene. The resident has a mid- , pressure , at 0.5 (centimeters-cm.) x 1 cm. x 0.2 cm. The nursing staff to teach and perform care on , and change dressing every three days. The RN discussed plan of treatment with caregiver.
- ' size - 0.5 cm. x 0.8 cm. x 0.1 cm. The had a yellow adhering center, resident is grossly incontinence.
/ - doctor orders to obtain culture and sensitivity of .
- ' 2 cm. x 1.5 cm. x 0.3 cm. The border gauze to be changed daily. Change in care - cleanse with cleanser, dry with gauze, apply ointment followed by damp gauze by border gauze changed daily.
- The resident has mild improvement, observed, moisture and positioning remain a challenge. The facility staff reeducated regarding prolonged sitting and moisture related issues.
/ - The resident has assessment for pain in her sacrum area, the resident sits in her chair most of the time and has not one to help her to bed off and on throughout the day. The caregiver was instructed to help patient change positions every 2 hours to upload for healing.
- RN talked to ALF (assisted living facility) nurses. ALF nurses stated if they have an order they will come and get her up every 2 hours. ARNP will be notified for order.
- 2 x 1.5 x 0.2. The facility is address on the care of the .

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/ - The resident has tremendous difficulty with mobility and requires for transfer. Continue to instruct caregivers on care.
/ - Order change, cleanse with cleanser, dry with gauze, add ointment.
/ - RN educated staff regarding importance of pressure relief and proper positioning.
/ - Resident now has a roho cushion for mattress for bed, the resident continues to rest 2 x per day, showing signs of improvement and .
/ - RN instructed facility to change position frequently to prevent pressure areas.
/ - RN instructed the facility to keep the clean and dry.
/ - RN instructed the facility to keep the clean and dry.
/ - The is not getting worse but it is not getting better.
/ - The facility is instructed to keep legs elevated with sitting to alleviate , the resident is reluctant to change position, the resident is unable to ambulate independently.
/ - , continues to heal. Decrease nursing to three times per week.
/ - The resident requires 1 on 1 assistance with all ADLs, instability and poor endurance, as well as atrophy, continue to education the facility on pressure relief through position changes, educated facility on standing resident 3 to 5 minutes to resident tolerance level to relieve pressure to and site.
- 0.1cm. x 1 cm. x 0.1 cm. RN to continue to educate facility to relieve pressure to hourly and apply barrier cream and each rest for protection and prevention of breakdown (per doctor orders).

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record reviews and interviews, the facility failed to protect resident privacy by requiring staff to take photos of logs with their personal cellular devices for 80 of 80 residents in the facility.

Findings:

On , review of the resident form documented after providing a medication to a resident, the form is copied into a personal cellular device and texted to staff B (Resident Care Manager).

On at 1:05 PM, staff M stated she is required to take a photo of the log book and send it to staff B (resident Care Manager). At 1:55 PM, staff N stated she is required to take a picture of the form and text it to staff B (Resident Care Manager). At 3:30 PM, staff O stated taking the photo

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of the form and texting it to staff B (Resident Care Manager) has been a policy for over a year. at 3:45 PM, Staff B (Resident Care Manager) stated the med techs (medication technicians) are required to take a photo with their personal cellular device of the form. The form is then texted to Staff B (Resident Care Manager) who responses to the med tech and they can erase the photo from their cellular device.

On at 9:54 AM, the administrator stated she is aware of the policy regarding med techs taking the photo of the residents' form with their personal cellular device. When asked how she knows if the med tech deletes the residents' personal information she stated they don't check the phones. The administrator stated she "trusts her staff ".

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation, record review and interviews, the facility placed 4 of 8 sampled residents at risk by failing to properly discard expired medication (#2, 6, 8 & 15).

Findings:

On at 4:30 PM, staff B (Resident Care Manager) stated she does weekly audits of the medication carts with the med techs (medication technicians). Staff B (Resident Care Manager) stated she audits the carts to make to make sure the med techs have the things they need in the carts.

On , a review was conducted on the auditing time line for medication carts. The time line documented weekly audits of all medication carts to ensure residents are obtaining medication and expired medication is removed. The time line is as follows: 1st shift on Wednesday, 2nd shift on Friday, 3rd shift on Monday for cart #1, Tuesday for cart #2, Memory Care - 1st shift on Tuesday and 2nd shift on Friday.

On , during an inventory of the facility medication carts, it was observed the facility had a number of expired medications stored in the cart with current medication which included: Resident #2 - Calmoseptin ointment expired ; and Flutcasime Furate expired ; Resident #6 - expired ; expired ; expired ; Resident #8 - expired ; and expired ; Resident #15 - expired .

On at 5 PM, the administrator denied having expired medication in the medication carts. The administrator stated staff B (Resident Care Manager) audits the carts weekly to ensure expired

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medication is removed.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observations, record review and interviews, the facility placed resident at-risk of life threatening harm by failing to reorder medication in a timely manner for 1 of 3 residents (#6).

Findings:

On at 10:20 AM, staff L stated Resident #6 is always out of medication.

On at 12 PM, an inventory of the medication for Resident #6 was completed. It was observed Resident #6 was out of Menantine, and only had the evening dosage of .

On at 3:10 PM, the local pharmacist provided the following information:
Menantine - the facility was provided a 7-day supply (14 doses/2x per day) on . The run out date was . The facility did not reorder additional medication until .
- the facility first request for the medication was . The medication is listed as a start date of .
- the facility was provided a 30-day supply on and an additional 10-day supply on . The run out of medication date was . The facility made a reorder request on .
- the facility was provided a supply for 30-day (60 doses/2x per day) on . The run out of medication date was . The facility requested a reorder on .

On , a review of Resident #6's medication observation record (MOR) was completed. It documented the following:
Menantine - run out date - MOR shows medication provided to .
- start date of - MOR documents medication provided to .
- run out date - MOR shows medication provided to .
- run out date - MOR shows medication provided from to .

On at 2:25 PM, the primary care physician (PCP) stated the medication is prescribed for the following reasons: Menantine for , for , for , and for . The PCP stated he will have to start new work regarding the .

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and we were "lucky" since one of the medication is used to prevent . The PCP stated it is concerning for the facility to not reorder the medication and this practice placed the resident at risk for harm of abnormal levels.

On at 3:40 PM, the spouse of Resident #6 stated the facility is responsible for ordering Resident #6's medication.

On at 9:06 AM, staff L stated Resident #6 has missed a large number of medications because the reorders never get made.

On , review of operating procedure for reordering medication read, "medication should be ordered from the preferred pharmacy when a 7-day supply is remaining in bubble pack/bottle."

On at 9:54 AM, the administrator stated the family of Resident #6 is responsible for reordering the resident's medication. The administrator stated it was to come from a local pharmacy down the street. The administrator was asked what responsibility the facility had taken when the resident ran out of critical medication, and she stated the responsibility belongs to the family.

On at 10:53 AM, the pharmacist at the pharmacy identified by the administrator denied working with the family or facility regarding Resident #6's medication.

On at 10:02 AM, the administrator stated the medication technicians have the responsibility to reorder medication. The administrator stated reorders are made when the medication gets down to the last 7 days. The administrator could not provide an explanation on why the medication ran out or if the medication had even been ordered.

Class II

0057 - Medication - Over The Counter (OTC) Products - 58A-5.0185(8) FAC

Based on observation and interviews, the facility is providing a stock supply of over the counter (OTC) medication for use by residents.

Findings:

On at 11:55 AM, an inventory of the medication carts was conducted. The observation revealed the facility had a stock supply of unlabeled OTC medication in the carts. These OTC medications were observed to be without resident names or health care providers order. The medication

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included Ocuvite, , C, Natural , Melatiomin, , 50 plus , Stool Softener, Probiotic, , and Acidophilum.

On at 5:10 PM, the administrator stated she would need to see a regulation that stated she had to have either the resident's name and how the medication is to be used if ordered from a doctor. The administrator stated she did not have to have the name of the resident on the label.

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 58A-5.019(1) FAC

Based on observation, record reviews and interviews, the administrator failed to maintain general oversight of the daily operation of the Assisted Living Facility. The administrator failed to implement operating procedures to ensure medications are refilled in a timely manner so as to not place residents at-risk of not receiving their medication as ordered by their primary care physician. The administrator failed to ensure expired medication had been removed from medication carts. The administrator failed to assess a resident with a for continued residency after 30 days of home health care.

Findings:

1. On , the operating procedure for reordering medication read, "Medication should be ordered from the preferred pharmacy when a 7-day supply is remaining in bubble pack/bottle."

On at 10:20 AM, Staff L stated Resident #6 is always out of medication.

On at 12 PM, an inventory of the medication for Resident #6 was completed. It was observed Resident #6 was out of Menantine, , and only had the evening dosage of .

On at 3:10 PM, the pharmacist at the local pharmacy provided the following information: Menantine - the facility was provided a 7- day supply (14 doses/2x per day) on / / . The run out date was . The facility did not reorder additional medication until - the facility first request for the medication was / . The medication is listed as a start date of / / . - the facility was provided a 30-day supply on / and an additional 10-day supply on / . The run out of medication date was / . The facility made a reorder request on - the facility was provided a supply for 30-day (60 doses/2x per day) on . The run out of medication date was / . The facility requested a reorder on .

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On , Resident #6's medication observation record (MOR) revealed the following: Menantine - run out date - MOR shows medication provided / to - start date of / , MOR documents medication provided to - run out date /, MOR shows medication provided /6 to - run out date / , MOR shows medication provided from / to / .

On at 10:02 AM, the administrator stated the medication technician (med tech) staff have the responsibility to reorder medication. The administrator stated reorders are made when the medication gets down to the last 7-days doses. The administrator could not provide an explanation why ran out or if the medication had even been ordered.

On at 9:54 AM, the administrator stated the family of Resident #6 is responsible for reordering his medication. The administrator stated it was to come from a local pharmacy down the street. The administrator was asked what responsibility the facility had taken when the resident ran out of critical medication and she stated the responsibility belongs to the family.

2. On , an inventory of the facility medication carts revealed the facility had a number of expired medications stored in the cart with current medication which included the following. Resident #2 - ointment expired /, and Filutcasime Furate expired /. Resident #8 - Lovastation expired , and expired /. Resident #15 - expired /. Resident #6 - expired / , expired , and expired .

On , review on the auditing time line for medication carts revealed the weekly audits of all medication carts to ensure residents are obtaining medication and expired medication is removed. The time line is as follows: 1st shift on Wednesday, 2nd shift on Friday, 3rd shift on Monday for cart #1, Tuesday for cart #2, and Memory Care - 1st shift on Tuesday and 2nd shift on Friday.

On at 4:30 PM, Staff B (Resident Care Manager) stated she does weekly audits of the medication carts with the med techs. Staff B (Resident Care Manager) stated she audits the carts to make sure the med techs have the things they need in the carts.

On / at 5 PM, the administrator denied having expired medication in the medication carts. The administrator stated Staff B (Resident Care Manager) audits the carts weekly to ensure expired medication is removed.

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3. On at 5:10 PM, the administrator stated Resident #7 has a pressure which is being treated by a home health nurse. The administrator provided the home health nurse notes.

On , review of Resident #7's file revealed only 5 entries in the nurses' notes. The file did not contain any additional information on the pressure beyond what was listed in the nurses' notes. They included the following: - Resident #7 is getting daily treatment, Resident #7 likes to lay in bed to rest; / - COC completed for resident obtaining ; / - ARNP (advanced registered nurse practitioner) stated pressure in starting to improve. Resident #7 slide and out of bed. / - ARNP reviewed pressure .

On , review of the home health nurses' notes provided by the facility revealed not to be nurses' notes but certification of services notes.

On / at 1:12 PM, the home health agency representative stated the home health agency would provide the nurses' notes for review. The representative stated she was familiar with Resident #7 and stated it had been documented Resident #7's was covered with fecal matter and from not being cleaned. The representative stated the facility was not compliant in supporting Resident #7. The representative stated if the facility had provided better care the pressure would have healed sooner.

On at 5:50 AM, Staff OO stated the resident care staff are responsible for turning Resident #7 every two hours. Staff OO showed the form used which was hanging on the . The form was blank.

On at 6:10 AM, Staff QQ stated Staff B (Resident Care Manager) goes over the care of Resident #7 in her meetings and stressed to keep her dry but most of the resident care staff are not at the meeting and don't know to keep her dry.

On at 9:26 AM, Staff M stated she is licensed to perform care and could keep the dressing clean and treated. Staff M stated she has been instructed to not perform those services.

On at 9:54 AM, the administrator stated the facility had provided all of the nursing notes which were provided by the home health agency. The administrator stated their duty is to provide a two hour check and to turn Resident #7. The administrator stated the information is documented on a form hanging on the . When asked who had the completed forms the administrator stated they are in Resident #7's file. When it was noted the file had been reviewed and no documentation on turning Resident #7 the administrator stated that is where it is kept. The administrator stated she is not

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aware of the status of the and if it is being staffed with the facility. The administrator stated the facility assessed the pressure to Resident #7 with the home health agency but did not have any documentation to support the assessment.

On at 2:35 PM, the home health registered nurse (RN) stated the facility did not follow the instructions left by her and the other RN's on the care of Resident #7. The RN stated most times when she went to care for Resident #7 she found the ' dressing wet and covered in fecal matter. The RN stated the facility never reached out to her and asked what she was doing or the condition of the resident.

On / at 9:41 AM, the home health RN stated she worked with Resident #7. The RN stated she always had a difficult time finding staff. The RN stated she would provide the staff direction on the care of Resident #7 but they did not follow up with Resident #7's needs. The RN stated she spoke to Staff B (resident Care Manager) but nothing was ever done.

On / at 10:02 AM, the administrator stated the facility provided the agency with all of the nurses' notes. The administrator stated the facility does not do ' care for residents. The administrator was unaware if the home health agency knew the facility did not provide ' care. The administrator stated the facility had access to the nursing notes on line but when shown the actual notes she acted as if it was the first time she had seen them. The administrator stated the home health nurses were available to provide care 24/7 for Resident #7 when the facility called.

On at 12:15 PM, the home health agency representative stated the facility did not contact the home health agency 24/7 if they needed support on the care of Resident #7. The representative stated the records document the facility never called.

Class II

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interviews, the facility failed to allow access to a communication log.

Findings:

On , the operating procedure for ordering and reordering resident medication read, "Staff is required to document all orders/reorders of medication in the 24 -hour report and communication book."

On / , during an attempted review of the 24-hour report and communication book, access to the

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communication book was denied by the facility administrator.

On at 1:10 PM, the administrator denied access to the 24-hour communication book stating, "this is not for you to review, you don't have any business reading it."

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Tiffany Collins
Family Extended Care of Melbourne, Inc./Century Oaks
4001 Stack Boulevard
Melbourne, FL 32901

, 2016

Dear . Collins:

This letter reports findings of a complaint investigation conducted from / / to / / by representatives of the Florida Agency for Health Care Administration. You are directed to comply with the tangible steps outlined in order to correct the deficient practices. Attached are the Class II deficiencies noted in the investigation.

The investigation resulted in findings of noncompliance with the follow areas:

A056 Medication labeling- Class II

The facility placed resident at-risk of life threatening harm by failing to reorder physician ordered medication in a timely manner.

A010 Admission- continued residency- Class II

The facility placed a resident at-risk by failing to properly assess a pressure for continued residency after 30 days of treatment by a home health agency. The facility failed to communicate or review home health agency nursing notes regarding the pressure .

A077 Staffing Standards-Administrator- Class II

The administrator has failed to maintain a general oversight of the daily operation of the Assisted Living Facility. The administrator failed to implement operation procedures to ensure medications are refilled in a timely manner so as to not place residents at-risk of not receiving their medication as ordered by their primary care physician. The administrator failed to ensure expired medication had been removed from medication carts. The administrator failed to assess a resident with a for

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Century Oaks
, 2017

continued residency after 30 days of home health care.

Your facility must comply with the following:

1- Your facility must work with a licensed pharmacist to write an operating procedure regarding the process of filling and refilling prescriptions for residents who require assistance with self-administration of medication prior to the resident running out of the medication. The operating procedure must document the steps the facility will take to ensure compliance with this task and how the administrator will track to ensure staff compliance.
2- Your facility must train all resident care staff including med techs on this operating procedure. This training must be completed by a licensed pharmacist. Your facility must provide a sign-in sheet documenting the attendance of staff at all of the trainings. Your facility must maintain a copy of the agenda, name of the licensed pharmacist and copies of the attendance sheets.
3- Your facility must write an operating procedure regarding continued admission of residents who require home health after a 30- day period. This operating procedure must include a face to face staffing with the home health provider and a requirement to review home health nursing notes which are kept in the facility on a daily basis. Documentation of the review of the home health nursing notes must be kept in the resident file.
4- Your facility must meet with all home health providers to ensure they are aware of the requirements of the facility. This meeting must include an agenda and copies of attendance.
5- Your facility must train all resident care staff on the above operating procedures. Your facility must maintain a copy of the training agenda and copies of the attendance.
The administrator must retake CORE training. **This shall be completed by , 2017.**

Please be advised that nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Shall you have any questions, please contact Lorraine Henry, Assisted Living Facility Supervisor at 407-420-2502.

Sincerely,

Theresa Decanio, RN
Field Office Manager

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