| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11965234** | **12/29/2016** |
| NAME OF PROVIDER OR SUPPLIER **ROSEWOOD GARDENS INC.** | STREET ADDRESS, CITY, STATE, ZIP CODE **643 NE LAGOON LANE PORT SAINT LUCIE, FL 34983** | |

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

**0000 - Initial Comments**

An unannounced relicensure survey was conducted on 12/29/2016 at Rosewood Gardens of Port Saint Lucie (License #9627). The facility had deficiencies at the time of the visit.

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

Based on observation and interview, it was determined the facility failed to ensure that each resident received access to adequate and appropriate health care consistent with established and recognized standards within the community, specifically related to staff failure to wash or sanitize hands when providing assistance with the self administration of medications, for 1 of 1 sampled residents observed during medication pass (Resident #1).

The Findings included:

During observation of Staff B (unlicensed staff) providing assistance with the self administration of 7 oral medications to Resident #1, on beginning at approximately 7:50 AM, he was not observed to wash or sanitize his hands.

During interview conducted with the Administrator, on beginning at approximately 11:00 AM, she was informed that Staff B did not wash or sanitize his hands prior to providing assistance with medications for Resident #1. She acknowledged that hand washing/sanitizing is required and expected prior to staff providing assistance with medications.

Class III

**0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)**

Based on observation, interview, and record review, it was determined the facility failed to ensure that unlicensed staff that provide assistance with the self administration of medications failed to follow procedures described in Section 429.256, F.S. specifically related to failure to inform resident of what medications they are being assisted with, for 1 of 1 sampled residents (Resident #1).

The Findings included:

During observation of Staff B (unlicensed staff member) providing assistance with the self administration of medications for Resident #1, on beginning at approximately 7:50 AM; he was observed to obtain the following medications from their labeled containers:

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11965234** | **12/29/2016** |
| NAME OF PROVIDER OR SUPPLIER **ROSEWOOD GARDENS INC.** | STREET ADDRESS, CITY, STATE, ZIP CODE **643 NE LAGOON LANE PORT SAINT LUCIE, FL 34983** | |

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

a) 20mg
b) DR 40mg
c) Vesicare 5mg
d) 5mg
e) 0.5mg
f) 3mg
g) CL ER 8meq

Staff B was not observed to inform Resident #1 of the names or type of medications being provided.

During interview conducted with the Administrator, on beginning at approximately 11:00 AM, she was informed that Staff B did not inform Resident #1 of what medications were being provided. The Administrator acknowledged that staff are to inform residents that receive assistance with the self administration of their medications when they are offered.

Class III

**0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC**

Based on interview and record review it was determined the facility failed to ensure that each staff member that provides assistance with the self administration of medications had obtained at least 2 hours of continuing education annually by a licensed registered nurse of a licensed pharmacist, for 2 of 2 sampled staff (Staff A and Staff B).

The Findings included:

During interview and personnel record review conducted with the Administrator, on beginning at approximately 10:30 AM; she was provided the opportunity to locate documentation to support that the following staff members had received at least 2 hours of continuing education related to providing assistance with the self administration of medications and safe medication practices in an assisted living facility:

a) Staff A - date of hire noted as /
b) Staff B - date of hire noted as

The Administrator acknowledged that the medication training provided on 01/ for Staff A and Staff B did not include the number of training hours provided by the registered nurse.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11965234 | 12/29/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**ROSEWOOD GARDENS INC.** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**643 NE LAGOON LANE**<br>**PORT SAINT LUCIE, FL 34983** | |

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

Class III

**0085 - Training - Nutrition & Food Service - 58A-5.0191(6) FAC**

Based on interview and record review, it was determined the facility failed to ensure that the Administrator had obtained, annually, a minimum of 2 hours of continuing education in topics pertinent to nutrition and food service in an assisted living facility for 1 of 1 sampled staff (Staff A).

The Findings included:

During interview and personnel record review conducted with the Administrator, on beginning at approximately 10:30 AM, she was provided the opportunity to locate 2 hours of annual nutrition training for the Administrator (she acknowledged she was the food service designee for this facility) for 2015 and 2016. The Administrator acknowledged there was no documentation on file for this training for 2015. The Administrator acknowledged that the training did not reflect how many training hours was provided.

Class III

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

Based on observation, interview and record review, it was determined the facility did not maintain a safe living environment that was free of hazards or adequate pest control services for 2 of 2 sampled residents (Resident #1 and Resident #2).

The Findings included:

An observational tour of the facility was conducted with the Administrator, on beginning at approximately 8:20 AM. The following concerns were identified at this time:
a) Broken floor tile at the entrance to Resident #1 and Resident #2's was exposing sharp edges. (photographic evidence obtained)
b) Broken foot board for Resident #1's bed that contained sharp edges. (photographic evidence obtained)
c) Small ants noted crawling up the wall (next to the dining table) and on the kitchen table in the kitchen area. (photographic evidence obtained)

The Administrator acknowledged all of these observations and stated she has pest control services for the ants. The pest control quarterly service report was the last report and visit provided for review. This was confirmed by the Administrator.

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11965234** | **12/29/2016** |
| NAME OF PROVIDER OR SUPPLIER<br>**ROSEWOOD GARDENS INC.** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**643 NE LAGOON LANE**<br>**PORT SAINT LUCIE, FL 34983** | |

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

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2017

Administrator
Rosewood Gardens Inc.
643 Ne Lagoon Lane
Port Saint Lucie, FL 34983

Dear Administrator:

This letter reports the findings of a state relicensure survey that was conducted on 29, 2016 by a representative 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 representative. Should you have any questions please call the field office at 561-381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/ch
Enclosure

XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida