STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965709	01/25/2017
NAME OF PROVIDER OR SUPPLIER **SAM'S ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1 PEBBLEWOOD LANE** **PALM COAST, FL 32164**	

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

Z815 Background Screening: Prohibited Offenses

Based on a review of employee records, the AHCA background screening website, and interview with staff, the facility failed to obtain a new level 2 background clearance prior to hire for 1 of 4 sampled employees whose records were reviewed (Employee B), following a 90 or more day break in employment for that employee.

The findings included:

A personnel file review conducted for Employee B revealed she was hired on / / as a Caregiver. She had an employment application dated / / which indicated she had worked for the same facility under different administration between 2014 and 2015. There was no additional employment information listed until her re-hire in 2016. Employee B had an AHCA level 2 background screening clearance eligibility date of , and a hire date with the facility / / . There was no former employment listed in her employment history.

A telephone interview was conducted with Employee B on / / at 3:50 pm. She confirmed she had worked for the facility under the previous administration until 2015, but taken time off for personal responsibilities. She confirmed she had returned to work in the facility in of 2016.

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0000 Initial Comments

On / , a change of ownership licensure survey was conducted at Sam's Assisted Living Facility (License #10049). Deficient practice was identified during the survey.

0008 Admissions - Health Assessment

Based on observations, a review of resident records, and interview with staff, the facility failed to obtain complete information on the resident health assessment (AHCA form 1823) for 2 of 2 sampled residents whose records were reviewed (Residents #1 and #3).

The findings included:

1. A record review conducted for Resident #1 found a resident health assessment signed by the physician on / . Resident #1 had diagnoses including , and was noted to require assistance with eating. She required total help with bathing, , dressing, transferring, and assistance with toileting. On page 2 of the assessment, the physician indicated that Resident #1 required help with her medication; however, he failed to describe the level of assistance she required. The last section of the assessment, which is intended to be completed by the Administrator to list the services offered or provided by the facility, was missing altogether.

2. Observations of Resident #3 were conducted on / between 10:50 am and 3:45 pm. Resident #1 was in her bed during the facility tour at 10:50 am, and was accompanied by a hospice aide and the hospice nurse. The nurse stated in an interview at this time that Resident #3 had just received a dressing change for the on her heels. She stated Resident #3 had a , on her left heel, and a , on her right heel. Observations throughout the survey revealed Resident #1 was unable to respond when spoken to, unable to follow simple instructions, and dependent on staff for her medications, feeding, toileting and bed mobility. She remained in her bed for the duration of the survey.

At 12:10 pm on / / , the Administrator was observed to feed Resident #3 a liquid lunch from a spoon. Resident #3 was barely able to open her mouth to take sips when offered, and only able to suck from the spoon with difficulty and significant spillage.

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A record review for Resident #3 found a resident health assessment completed and signed by the examining practitioner on . The assessment was outdated by 2 years (an updated assessment was required by). The examiner documented that Resident #3 had diagnoses including and . She was assessed as being independent with ambulation and transfers, and required only supervision with eating, self-care, and toileting. Resident #3 was assessed as requiring assistance with bathing and dressing. Resident #3 was noted to be free of at the time of the examination. The last page of the assessment, which is intended to be completed by the Administrator to list services offered or provided by the facility, was missing altogether.

An interview was conducted with the Administrator at 11:30 am on / / . She searched for a more current resident health assessment for Resident #3, but was unable to locate one.

In a second interview with the Administrator at 3:15 pm on / , she confirmed the incomplete and inaccurate information on the resident health assessments for Residents #1 and #3.

Class III

0052 Medication - Assistance with Self-Admin

Based on observations, resident record reviews, and interview with staff, the facility failed to to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule for 1 of 1 resident who required medication administration (Resident #3), out of a total of 3 residents.

The findings included:

An observation of Resident #3 was conducted on / at 12:08 pm in her . The Administrator brought a pharmacy-issued bottle of Hydrocod/ 7. tablets (used to manage pain) into the , along with a marble mortar and pestle. The Administrator poured one tablet into her hand, and placed it in the cup-shaped mortar. Using the pestle, she crushed the pill to a fine grind, and poured it into a bowl containing the resident's liquid lunch. She fed the mixture containing the medication to the resident using a spoon. Resident #3 did not assist an any way other than to suck the soupy mixture from

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the spoon when placed to her mouth.

A record review for Resident #3 found a resident health assessment signed by the examining practitioner on . On page 4 of the assessment, the examiner documented that Resident #3 needed her medications administered, and commented that she was unable to self-medicate.

An interview with the Administrator at 3:15 pm on / confirmed she was not a nurse. She did not know a nurse was required to administer medications to residents unable to assist.

Class III

0053 Medication - Administration

Based on observations, resident record reviews, and interview with staff, the facility failed to provide a staff member licensed to administer medications for 1 of 1 resident who required medication administration (Resident #3), out of a total of 3 residents.

The findings included:

An observation of Resident #3 was conducted on / at 12:08 pm in her . The Administrator brought a pharmacy-issued bottle of Hydrocod/ 7. milligram tablets into the , along with a marble mortar and pestle. The Administrator poured one tablet into her hand, and placed it in the cup-shaped mortar. Using the pestle, she crushed the pill to a fine grind, and poured it into a bowl containing the resident's liquid lunch. She fed the mixture containing the medication to the resident using a spoon. Resident #3 did not assist an any way other than to suck the soupy mixture from the spoon when placed to her mouth.

A record review for Resident #3 found a resident health assessment dated / and signed by the examining practitioner. On page 4 of the assessment, the examiner documented that Resident #3 needed her medications administered, and commented that she was unable to self-medicate.

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An interview with the Administrator at 3:15 pm on I/ confirmed she was not a nurse. She did not know a nurse was required to administer medications to a resident who was unable to assist.

Class III

0078 Staffing Standards - Staff

Based on observation, resident and staff record reviews, and interviews with staff, the facility failed to ensure staff submitted a written statement from a health care provider documenting the absence of signs or symptoms of communicable including for 4 of 4 employees whose files were reviewed (Employees A, B, the Administrator, and the Relief Person). The facility also failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience for 1 of 1 employee (the Administrator) observed for assistance with medication administration.

The findings included:

1. A personnel file review conducted for Employee A revealed he was hired in 2004 as a Caregiver. Further review of his record revealed no annual statement from a health care practitioner that he was free from signs/symptoms of .

2. A personnel file review conducted for Employee B revealed she was hired on I/ as a Caregiver. Further review of her record revealed no statement from a health care practitioner that she was free from signs/symptoms of .

3. A personnel file review conducted for the Administrator revealed she became Owner/Licensee of the facility on I/ . Further review of her record revealed no documentation from a health care provider that she was free from communicable .

4. A personnel file review conducted for the Relief Person revealed she became Owner/Licensee of the

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facility on 11/30/2016. Further review of her record revealed no documentation from a health care provider that she was free from communicable

5. An observation of assistance with medication for Resident #3 was conducted on / at 12:08 pm. The Administrator brought the resident's prescribed medication into the resident's , along with a marble mortar and pestle. She poured one medication tablet from the bottle into her hand, placed it in the mortar, and crushed the tablet using a pestle. After pouring the crushed tablet into Resident #3's lunch, she fed the mixture to the resident with a spoon. Resident #3 did not assist an any way other than to suck the soupy mixture from the spoon when placed to her mouth.

A record review for Resident #3 found a resident health assessment dated / and signed by the examining practitioner. On page 4 of the assessment, the examiner documented that Resident #3 needed her medications administered, and commented that she was unable to self-medicate.

An interview with the Administrator at 3:15 pm on / / confirmed she was not a nurse. She did not know a nurse was required to administer medications to a resident who was unable to assist.

Class III

0081 Training - Staff In-Service

Based on a review of employee files, and interview with the Administrator, the facility failed to ensure staff received the required in-service trainings prior to working with the residents, or within 30 days of hire, to 3 of 4 employees whose training records were reviewed (Employees A, B and the Relief Person).

The findings included:

1. A personnel file review conducted for Employee A revealed he was hired in 2004 as a Caregiver. Further review of his record revealed no documentation of the required training in the recognition and reporting resident , neglect, and within 30 days of his hire.

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2. A personnel file review conducted for Employee B revealed she was hired on 12/1/16 as a Caregiver. Further review of her record revealed no documentation she had received the required training in control prior to working with the residents. There was no documented evidence she received the required 3-hour training in activities of daily living (ADLs) and resident behavior and needs, or the 1-hour of training covering reporting major incidents, facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation, resident rights, recognizing and reporting resident , neglect, and , or the facility elopement response policies and procedures within 30 days of employment.

3. A personnel file review conducted for the Relief Person revealed she became Owner/Licensee of the facility on / . Further review of her record revealed no documentation that she received she received the required 3-hour training in activities of daily living (ADLs) and resident behavior and needs, or the 1-hour of training covering reporting major incidents, safe food handling , facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation, resident rights, recognizing and reporting resident , neglect, and , or the facility elopement response policies and procedures within 30 days of employment.

4. An interview was conducted with the Administrator at 3:15 pm on / . She reviewed the personnel files and confirmed the missing trainings for Employees A, B and the Relief Person.

Class III

0082 Training - / /

Based on a review of employee files, and interview with the Administrator, the facility failed to ensure staff was provided the required in-service trainings in / / (/) within 30 days of hire, for 2 of 4 employees whose training records were reviewed (Employees B and the Relief Person).

The findings included:

1. A personnel file review conducted for Employee B revealed she was hired on / as a Caregiver.

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Further review of her record revealed no documentation she had received the required training in / within 30 days of hire.

2. A personnel file review conducted for the Relief Person revealed she became Owner/Licensee of the facility on /. Further review of her record revealed no documentation that she received she received the required training in / within 30 days of hire.

4. An interview was conducted with the Administrator at 3:15 pm on /. She reviewed the personnel files and confirmed the missing trainings for Employees B and the Relief Person.

Class III

0090 Training -

Based on a review of employee files, and interview with the Administrator, the facility failed to ensure staff was provided the required one hour of in-service training in ( ) within 30 days of hire, for 1 of 4 employees whose training records were reviewed (Employee B).

The findings included:

1. A personnel file review conducted for Employee B revealed she was hired on / / as a Caregiver. Further review of her record revealed no documentation she had received the required one hour of training in the facility policy and procedure on within 30 days of hire.

2. An interview was conducted with the Administrator at 3:15 pm on /. She reviewed the personnel file and confirmed the missing training.

Class III

0093 Food Service - Dietary Standards

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Based on observation, facility record review, and interview with the Administrator, the facility failed to note meal substitutions before or when the meal was served for 3 of 3 residents observed at lunch (residents #1 #2 and #3). The facility also failed to keep documented substitutions on file in the facility for 6 months.

The findings included:

An observation of the lunch meal was conducted on / at 12:05 pm. Resident #3 was observed to be fed a lunch of oatmeal and bananas mixed with a full can of a strawberry nutritional shake. Residents #2 and #3 received a slice of pizza, and peas, with a can of the same nutritional shake.

Review of the facility menu, which was signed by the Registered Dietician on , revealed the lunch meal for the day of observation called for 6 ounces of vegetable soup, 2 packages of crackers, ½ cup tuna salad, 2 slices of wheat bread, ½ cup carrot raisin salad, 2 pear halves, and 8 ounces of milk.

An interview was conducted with the Administrator at 3:00 pm on / . She confirmed there were no substitution logs being maintained by the facility.

Class III

0162 Records - Resident

Based on observation, a review of resident records, and interview with staff, the facility failed to maintain complete resident records that included semi-annual documentation of weights for 2 of 3 residents whose records were reviewed (Residents #1,and #3).

The findings included:

1. A record review conducted for Resident #1 found a resident health assessment completed by her physician on . Resident #1 had diagnoses including , and was noted to require assistance with eating. Her weight was omitted from the first page of the assessment. Further review of

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the resident and facility records found there were no weights recorded on a semi-annual basis for Resident #1, as required.

2. At 12:10 pm on / , the Administrator was observed to feed Resident #3 a liquid lunch from a spoon. Resident #3 was barely able to open her mouth to take sips when offered, and only able to suck from the spoon with difficulty and significant spillage.

A record review for Resident #3 found a resident health assessment dated / . The assessment indicated Resident #3 had diagnoses including and . Further review of the resident and facility records found there were no weights recorded on a semi-annual basis for Resident #3, as required.

An interview was conducted with the Administrator at 12:49 pm on / / . She stated both residents #1 and #3 were under the care of hospice, and the hospice provider had stated they would monitor weights. The Administrator confirmed that both residents required assistance with activities of daily living, and that there were no weights, as required, for Residents #1 or #3.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Sam's Assisted Living Facility
1 Pebblewood Lane
Palm Coast, FL 32164

Dear Administrator:

This letter reports the findings of a state licensure Change of Ownership survey that was conducted on , 2017 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 surveyor. Should you have any questions please call this office at -4201.

Sincerely,

amanda wisehart

Amanda Wishehart
Health Facility Evacuator Supervisor
Division of Health Quality Assurance

LL/AW/sm
Enclosure
XG90

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