STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966792	**02/08/2017**
NAME OF PROVIDER OR SUPPLIER **GUARDIAN ELDER CARE SERVICES INC (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **10930 S W 143 COURT** **CROSSINGS, FL 33186**	

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

0000 - Initial Comments

A standard biennial survey was conducted , , 2017. Guardian Elder Care Services Inc (the) with License # 10984 had the following deficiencies identified at the time of the survey:

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

Based on observation, interview and record review, the Assisted Living Facility failed to obtain an updated health assessment which accurately reflected the resident's health condition for one out of six sampled residents (Resident #3). The resident's receipt of hospice services was not document.

Findings included:

Observation on at 7:30 AM revealed that Caregiver C placed a spoon with medicine inside Resident #3's mouth.

In an interview on at 8:48 AM, Caregiver C stated, "Resident #3 has a that doesn't allow cooperating in anything, and I have to give them to her in the mouth. She doesn't eat or drink by herself."

Review of Resident #3's record revealed that the last health assessment (AHCA form 1823) was completed on and it showed that Resident #3 needed assistance for ambulation, bathing, dressing, self-care, toileting, and transferring and needed supervision for eating. Resident was bedridden and in comments showed hospice. Resident #3 needed assistance with self-administration of medication.

Review of Resident #3's hospice record showed that referral date for hospice was on and admission date was . The resident's diagnosis was . The last plan of care review was done on and showed that resident was dependent for 6/6 activities of daily living.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview and record review, the Assisted Living Facility failed to update the written record regarding an incident that resulted in medical attention, for one out of six sampled residents (Resident #5) .

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Findings included:

Observation on at 7:57 AM revealed that Resident #5 had dark skin discoloration around the left eye.

In an interview on at 7:57 AM, Resident #5 revealed that she and hit the floor at the clinic when she went to buy a lotto ticket.

A review of Resident #5's record revealed that there was no documentation that explained why Resident #5 had a dark skin discoloration around the left eye, and no medical documentation from the .

In an interview on at 8:03 AM , Caregiver B revealed that Resident #5 at the clinic, and that the resident's nephew went with her to have a done. Caregiver B further stated that the clinic did not send any report. Caregiver B said "We knew what happened because the driver told us. The was done at the clinic. There was no documentation completed by the facility."

An interview on at 10:40 AM with the Administrator revealed that Resident #5 felt at the clinic. The driver brought her back to the facility without any documentation. The Administrator called Resident #5's nephew and informed him. He does not care about the Resident's care. The Administrator stated that she did not write a report because it did not happen in the facility. That was last week, on Monday and the nephew took her back to the doctor.

Class III

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

Based on observation and interview, the Assisted Living Facility failed to ensure that six of six residents were treated with consideration and respect, and with due recognition of dignity (#1-6). Caregivers slept in common living areas. Caregiver beds and bed dressings were stored in a resident's .

Findings included:

Observation on at 7:12 AM revealed that there were two folding beds in the living .

Interviewed on at 7:12 AM, Caregiver B stated, "sorry about the mess".

Observation on at 7:16 AM the Caregiver B picked folding beds from living and put them in the private .

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Interviewed on at 7:20 AM, Caregiver B revealed that Resident #2 slept in the Private .

Observation on at 7:20 AM revealed that there were four folding beds stored in the Private .

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on observation and interview, the Assisted Living Facility failed to ensure that a licensed person administered medication to one out of six sampled residents.(Resident #3).

Findings included:

Observation on at 7:30 AM revealed Caregiver C assisted Resident #3 with her medicines. Caregiver C stated, "Resident #3 lets take your medicines". Caregiver C stated "I don't tell her the names of the medicines because she did not retain them."

Observation on at 7:31 AM revealed that Caregiver C put medicines into a spoon one at a time with thickened water, then placed the spoon into Resident #3's mouth.

Record review showed that Caregiver C was not a licensed health care provider.

Interviewed on at 8:48 AM the Caregiver C stated, "Resident #3 has a that doesn't allow cooperating in anything and I have to give them to her in the mouth. She doesn't eat or drink by herself."

Class III

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

Based on record review and interview, the Assisted Living Facility failed to ensure that the caregiver assisting residents with self-administration of medication updated the Medication Observation Record (MORs) immediately each time the medication was offered or administered for one of six sampled residents (Resident #3).

Findings included:

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Review of Resident #3's MORs revealed that there was an order of Silver 1% cream apply twice a day and it was scheduled at 8 AM and 8 AM. The medication had not been initialed at any time in , 2017.

Interviewed on at 8:46 AM, the Caregiver C revealed that the ointment came in a little tube. It was not enough, and is running out. It still has some, but we decided to not initial for it, and that way when it finishes, we don't have to stop initialing. The owner told me to do it that way and the ointments do not need to be initialed. "

Class III

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

Based on observation an interview, the Assisted Living Facility failed to keep medication locked at all times.

Findings included:

Observation on at 7:22 AM revealed that there was a bottle of in a refrigerator labeled "STAFF".

Interviewed on at 7:22 AM, Caregiver B, Rosa, stated, "It belongs to her",referred to Caregiver D. Caregiver B further stated "Yes, this refrigerator is for the use of residents."

Class III

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

Based on observation and record review, the Assisted Living Facility failed to maintain a written work schedule that accurately reflected its 24-hour staffing pattern.

Findings included:

Observation on at 7:12 AM revealed that Caregivers B, C and D were in the facility taking care of six residents (Residents #1-6).

Review of staffing schedule revealed that on Caregiver B was not scheduled to work, Caregiver C worked from 7 AM to 7 PM and Caregiver D from 8 AM to 5 PM.

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Class III

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

Based on record review and interview, the Assisted Living Facility failed to ensure that one of five caregivers received the elopement training within 30 days of employment (Caregiver D).

Findings included:

A review of Caregiver D's personnel record revealed that Caregiver D's hire date was . There was no documentation of the caregiver having completed the elopement training.

Interviewed on at 2:40 PM, the Administrator stated, regarding the documentation, "I can't find it."

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, record review and interview, the Assisted Living Facility failed to note menu substitutions before or when meals were served.

Findings included:

Observation on at 7:13 AM revealed that Caregiver D served breakfast to Residents #1, #2, #5, and #6. Breakfast was one piece of toast with butter, a cup of milk, a cup of water and a bowl of dry cereal.

A review of the facility's menu for showed for breakfast: assorted juices, ¾ cup of dry cereal, 4 Cuban crackers, margarine, and milk. Further review of the menu showed that no substitutions were written.

Interviewed on at 9:52 AM, Caregiver D revealed that there were no Cuban crackers and she substituted them with bread, and she changed juice for milk.

Class III

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0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and interview, the Assisted Living Facility failed to provide documentation of the valid appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for two (Residents #3 and #4) out of six sampled residents.

Findings included:

Review of Resident #3's record revealed that Resident #3's daughter signed the inform consent that unlicensed staff could assist the resident with self-administration of medication on . There was not documentation on record appointing Resident #3's daughter as the health care surrogate, health care proxy, guardian, or the power of attorney.

Interviewed on at 12:07 PM, the Administrator revealed that Resident #3's daughter has been signing but there was no power of attorney on record at the time of the survey.

Interviewed on at 12:20 PM, Resident #4 revealed that she had a power of attorney at her home but she has to look for it.

Class III