STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968790	**03/09/2017**
NAME OF PROVIDER OR SUPPLIER **ANGELS WINGS SYNERGY RETREAT, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **1920 N 44TH ST** **FORT PIERCE, FL 34947**	

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

0000 - Initial Comments

A Relicensure survey with Limited Mental Health was conducted on and at Angels Wings Synergey Retreat, License #12653. The facility had deficiencies at the time of the visit.

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

Based on observation, interview and record review, the facility failed to have an updated health assessment (AHCA Form 1823) completed, for 1 of 3 residents who had a significant change (Resident #2).

The findings include:

On , a review was conducted of Resident #2's current Health Assessment, dated . This assessment documented resident's height at 5'7" and his weight at 174.5 lbs. , was documented as a part of his diagnoses. The current health assessment contained no documentation of this resident's dietary needs. The assessment also documented that Resident #2 needed assistance with all Activities of Daily Living (ADLs).

A review was conducted of Resident #2's weights. At time of admission, Resident #2 weighed 210 lbs. He maintained that weight until he went into the hospital on due to being hit by a car while attending his day program. Upon discharge from hospital, Resident #2's Health Assessment, dated , recorded resident's weight at 174.5. Weight taken and recorded by the facility on shows resident weight at 210 lbs. Weight recorded for was 212 lbs. Weight taken and recorded on was 184, which was a 28 lb weight loss in less than 30 days, which is a significant weight loss. There is no documentation within the resident's chart acknowledging or explaining reason for such a significant weight loss. There was also no documentation as to a planned weight loss program for Resident #2, or a change in medication during this time.

On and , observations were made of Resident #2 being independent with all his Activities of Daily Living (ambulation, transfers, dressing, toileting, eating, , etc).

During interview with Resident #2 on at 10:41 AM, he states, "The staff help me with washing my clothes and my medications. I do everything else myself."

During interview with Administrator on at 9:00 AM, she confirms Resident #2 is independent with his ADLs and that the current Health Assessment was done soon after Resident #2 had his accident and

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needed assistance with his ADLs. She stated, "He has really improved and come a long way." When asked about Resident #2's significant weight loss on at 9:00 AM, she stated "I wasn't aware of a significant weight loss," and she could not provide a reason why resident would have lost so much weight. The administrator did acknowledged that all the weights documented were correct.

On at 9:10 AM, Resident #2 was weighed on 2 of the facility scales while surveyor observed. Resident #2's weight on scale #1 was 179 and scale #2 read 178.

Interview with Resident #2 on at 9:13 AM revealed Resident was aware of some weight loss but could not explain why. He did state, "I haven't had much of an appetite, but I do eat a good lunch while at program."

On at 9:19 AM, the Administrator acknowledged Resident #2 needed to have a face-to-face examination with a new health assessment completed due to significant change in resident's weight and ADLs.

Class III

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

Based on record review and interviews, the facility failed to:
1) notify physician and other appropriate party regarding significant; change for 1 of 3 residents (Resident #2), and
2) maintain a written record of any significant changes.

The findings include:

A review was conducted of Resident #2's weights. At time of admission, Resident #2 weighed 210 lbs. He maintained that weight until he went into the hospital on due to being hit by a car while attending his day program. Upon discharge from hospital, Resident #2's Health Assessment, dated , recorded resident's weight at 174.5. Weight taken and recorded by the facility on shows resident weight at 210 lbs. Weight recorded for was 212 lbs. Weight taken and recorded on was 184, which was a 28 lb weight loss in less than 30 days, which is a significant weight loss.
There is no documentation within the resident's chart acknowledging or explaining reason for such a significant weight loss.
There was also no documentation as to a planned weight loss program for Resident #2, or a change in

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medication during this time.

During interview with Administrator on at 9:00 AM regarding Resident #2's significant weight loss, she stated, "I wasn't aware of a significant weight loss," and she could not provide a reason why resident would have lost so much weight. The administrator did acknowledged that all the weights documented were correct.

On at 9:10 AM, Resident #2 was weighed on 2 of the facility scales while surveyor observed. Resident #2's weight on scale #1 was 179 and scale #2 read 178.

Interview with Resident #2 on at 9:13 AM revealed Resident was aware of some weight loss but could not explain why. He did state, "I haven't had much of an appetite."

The administrator acknowledged on at 9:15 AM that she had not notified Resident's physician or his Case Worker regarding a significant weight loss for Resident #2.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on observation, interview and record review, the facility failed to ensure 1 of 1 at risk resident have identification on their person that includes their name, facility name, address, and telephone number; and that the same at risk resident has photo identification on file within 10 days of being accessed as an elopement risk.

The findings include:

On , during record review for Resident #2, it was noted on the current Health Assessment (AHCA Form 1823), dated , that this Resident has 's and is an elopement risk.
Review of Resident #2's file revealed there was no identification photo of Resident #2 anywhere within her medical chart.
Observations of Resident #2 on at 10:24 AM and on at 12 Noon did not reveal any personal identification information being worn by this resident on their person.

At approximately 1:30 PM, after Resident #2 had eaten her lunch, and the other 2 residents were at Day Program, the Resident Care Aide stated she was taking her lunch break and left the . The Resident Care Aide was not seen by surveyor for over 30 minutes. Resident #2 was napping in her recliner during this time. This facility is not a secured facility.

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An interview was conducted with Resident Care Aide on at 2:30 PM. She confirmed she provides ADL care for this Resident and states, "I have never seen any identification information being worn by the resident."

During an interview conducted with the Administrator on at 11:00 AM confirmed Resident #2 does not have a photo identification in her medical chart, nor does Resident have identification information on her person.

Class III

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

Based on observation and staff interview, Staff A failed to follow standard procedures described in Section 429.256 F.S. for assisting residents with self-administered medications for 3 of 3 residents (Resident #1-#3).

The findings include:

During the observance of assistance with self-administered medications for Residents #1, #2 and #3, Staff A washed her hands and donned disposable gloves before beginning medication assistance for Resident #2. While in the kitchen, Staff A removed packaged medications for Resident #2 from a locked medication box and proceeded to place all of Resident #2's required morning medications into a small plastic cup. She placed the medication packages/containers back into the medication box and locked it. She took the plastic cup containing all of the Resident's pills to Resident #2 while he was in his , and she handed him the cup and watched him take his medication.

Staff A, then, went back to the kitchen and removed the medication package/container for Resident #2 from her locked medication box, and she placed all medications into a small plastic cup. She placed medication package/container back into the box and took the medication cup to Resident #3, who was sitting at the dining , and watched her take the pills. Staff A completed the same routine for Resident #3, who was also sitting at the dining .

Staff A did not perform the following regulatory procedures related to assisting with self-administered medications:
a) Staff A did not change gloves and/or sanitize her hands in -between residents;
b) Staff did not take the medications in its previously dispensed, properly labeled containers/packages from where it was stored and bring them to the resident;

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c) In the presence of the resident, read the medication label;
d) Remove the proper dosage of medication from the container/package and placing it into resident's hand or small cup, in the presence of the resident. after the label was read.

Administrator acknowledged, during interview on at 8:45 AM, Staff A did not follow regulatory procedure related to assisting with self-administered medications.

Class III

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

Based on record review and staff interview, the facility failed to:
1) Have a person, designated in writing, to be in charge of the facility in the event the Administrator is absent for more than 48 hours.
2) Maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period.

The findings include:

1) During an interview with the Administrator on at approximately 11:15 AM, the Administrator stated that she had recently been in Hallandale for a job which had lasted for approximately 20 days. She stated she was away Monday - Thursday, and she had returned to the facility on the weekends. When asked who was designated in writing to be in charge of the facility in her absence, the Administrator stated, "My mother-in-law lives nearby and she was available. She is a CNA (Certified Nurse's Aid) and her home is licensed." The Administrator confirmed she did not have a person designated in writing to be in charge of the facility in her absence. No evidence could be found that this person has a licensed facility, but she does have a valid CNA certification and current background screening.

2) On at 9:30 AM, a written staffing schedule was requested from Staff A. Staff A provided me with staffing schedule dated - and - . The schedules contained only the staffing hours for Staff A, and she stated that, as far as she knew, she was the only staff currently employed by the facility. No other staffing schedules were provided to cover staffing hours for when Staff A was not scheduled.
On at 11:20 AM, the Administrator confirmed she did not have a 24 hour written staffing schedule completed.

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Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on record review and staff interview, the facility did not ensure a staff member who has completed courses in First Aid, and holds a currently valid card documenting completion of such courses, was in the facility at all times (Staff A).

The findings include:

On , during record review for Staff A, there was no evidence showing Staff A completing an accredited First Aid course, or held a currently valid First Aid Certification card.

Staff A stated on at 2:40 PM, "I took the class, and I thought the First Aid was included, but my card only has on it; so, I guess I don't have the First Aid."

Staff A was observed to be the only employee in the facility with the residents on from 9 AM - 4 PM

The Administrator acknowledged lack of First Aid training for Staff A on at 8:45 AM.

Class III

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

Based on record review and staff interview, the facility failed to ensure 1 of 2 facility staff, who assist with residents' medications, completed the annual 2 hour update for Assistance with Self-Administered Medications (Staff B).

The findings include:

On , during review of Staff B's employment record, the last Assistance with Self-Administered Medications Training certificate found was for a 6 hour training completed on .

During interview with the Administrator on at 8:50 AM, she confirmed that she does provide medication assistance to the residents, The Administrator stated, "I was sure I completed the 2 hour annual training in 2016;" but after several minutes of searching, she admitted that she was unable to provide a training certificate showing completion of the required 2 hour annual update for 2016..

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Class III

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

Based on record review and staff interview, the facility failed to ensure the appointed Food Designee completed the annual 2 hour Food and Nutrition Training (Staff B).

The findings include:

On . . . . . , during review of Staff B's employment record, no training certificates showing completion of any 2 hour Food and Nutrition Trainings were located.

During interview on at 8:50 AM, Staff B confirmed she was the Food Designee. She acknowledged she could not provide any certificates showing completion of the annual 2 hour Food and Nutrition Trainings for 2015 or 2016.

Class III

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

Based on observation, interviews, and record reviews, the facility failed to:
1) Follow approved dietary menus and substitute items with comparable nutritional value; and note substitutions before or when meal is served; and
3) Post menus in a conspicuous area, easily available to residents.
This affects all residents who eat their meals at the facility.

The findings include:

1) During lunch meal observation conducted on , only Resident #1 was served the lunch meal, as Resident #2 and Resident #3 had their lunch meal while attending their Day Programs.

Review of the lunch meal listed on the approved menu for . . . . . documented the following meal was to be served: 1 cup Turkey Sausage and Lentil Soup, 1 cup Pasta Salad with Green Beans, Tomatoes, and Roasted Peppers; 6 oz beverage of choice.

The meal served to Resident #1 was a bowl of vegetable soup with some added pasta and a plate of pasta Salad with green beans and tomatoes. There was no protein substitution for the turkey sausage or lentils in this meal.

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Interview conducted with Certified Nurse's Aide (CNA) on . . . . at 12:30 PM revealed that she was unaware of the need to substitute meal items with comparable nutritional value. When asked why the menu wasn't followed, the CNA stated, "The food items were not available." The CNA also stated that when a food is substituted, she will put it on the Substitution Log after the meal is served.

3) During tour of the facility on . . . . at 10:00 AM, the weekly menu was not observed in any of the common areas. When the CNA was asked for the location of the menu, she pointed out that it was located in the kitchen, propped upright on the counter. The location of the menu was not in an area that is conspicuous and easily available to all of the residents.

On at 10:30 PM, Resident #1 was asked if she knew where to find the weekly menu to find out what was going to be served during the week, she replied, "No, I just eat what they give me."

On . . . . at 11:30 AM, the Administrator acknowledged the need to post weekly meal menu in a location that is where it is conspicuous and available to all residents.

Class III

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

Based on record review and staff interview, the facility failed to maintain the employment status of all employees within the clearinghouse within 10 business days.

The findings include:

On . . . . . , the Agency's Background Screening (BGS) Clearinghouse was reviewed for this facility's up-to-date employee roster. At the time of review, the facility had a list of 3 employees that were hired in , 2016 and . . . 2016. None of these employees were currently employed at the facility; however, none of these 3 employees had an end date of employment.

The current employee, Staff A, whose hire date was , was not found on the employee roster. The Administrator's mother-in-law, who the Administrator stated was the person who would be in charge in the Administrator's absence, was also not listed among the facility's employees.

On at 8:50 AM, the Administrator acknowledged she had not updated the BGS Clearinghouse with current/past employee information.

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